CONSUMER SERVICES REVIEW
FOR AN ADULT SERVICE PARTICIPANT

A REUSABLE PROTOCOL OR EXAMINATION OF ADULT MENTAL HEALTH AND ADDICTION SERVICES

INITIAL FIELD USE VERSION-1B

DEVELOPED FOR

THE INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION,
DIVISION OF MENTAL HEALTH AND ADDICTION

BY
HUMAN SYSTEMS AND OUTCOMES, INC.

MAY 2006

THE CONSUMER SERVICES REVIEW FOR ADULTS

This protocol is designed for use in a consumer-focused, recovery-oriented Quality Service Review process developed by Human Systems and Outcomes, Inc. (HSO). It is used for: (1) appraising the current status of persons receiving services (e.g., adults with serious and persistent mental illness) in key life areas, (2) reviewing recent progress, and (3) determining the adequacy of performance of key practices for these same persons. The protocol examines short-term results for adults with mental illness and the contribution made by local providers and the service system in producing those results. Consumer-based review findings will be used to assess current practice and to stimulate and support efforts to improve services for adult consumers who are residents of Indiana.

These working papers, collectively referred to as the *Consumer Services Review Protocol*, are used to support a professional appraisal of adult participant status and service system performance for specific persons in a specific service area and at a given point in time. This protocol is not a traditional measurement instrument designed with psychometric properties and should not be taken to be so. Localized versions of quality service review protocols are prepared for and licensed to service agencies for their use. The QSR is based on a body of work by Ray Foster, PhD and Ivor Groves, PhD of HSO.

Proper use of the *Consumer Services Review Protocol* and other QSR processes requires reviewer training, certification, and supervision. Supplementary materials provided during training are necessary for reviewer use during case review and reporting activities. Persons interested in gaining further information about this process may contact an HSO representative at:

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INTRODUCTION TO THE CONSUMER SERVICE REVIEW PROTOCOL

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Listed below is the table of contents for this CSR protocol. In addition to these materials, reviewers are provided a set of additional working papers that are used for reference and job aids used for particular tasks conducted during the review.

INTRODUCTION TO THE CONSUMER SERVICE REVIEW PROTOCOL

UNDERSTANDING PRACTICE AND RESULTS

The Consumer Service Review (CSR) uses an in-depth case review method. It applies a performance appraisal process to find out how participants are benefiting from services received and how well local services are working for a sample of participants at a point in time. Each person served is a unique "test" of the service system. Small representative groups of service participants are reviewed to determine their current status and related system performance results.

Questions about how an adult service participant is doing include:

- Is the person safe from manageable risks of harm caused by others or by him/herself? Is he/she free from abuse/neglect?
- Does the person have adequate living arrangements and income to cover basic living requirements?
- Are the person's basic physical and health needs met?
- Does the person have the opportunity to pursue personal goals and aspirations in rehabilitation, recovery, education, and career?
- Is the person connected to a natural support network of friends, family, and peers?
- Is the person making progress in symptom management, recovery, and personal goals?

Positive answers to these questions show that persons served by local staff and service providers are doing well. When negative patterns are found, improvements can and should be made to strengthen frontline practice, working conditions, and services.

Questions about how well the service system is working include:

- Does the person, clinicians, supporters, and service providers share a "big picture" understanding of the person's situation, needs, strengths, preferences, and goals so that sensible supports and services can be provided?
- Do the "service partners" know and understand the personal recovery goals and how to use services to enable the person to achieve his/her therapeutic and personal recovery goals?
- Does the person have an individualized service plan that organizes treatment strategies, supports, and services to be provided, spans all involved service providers, and is responsive to the person's directions, preferences, and goals?
- Are services and service approaches integrated across providers and settings to achieve positive results for the person?
- Are family members or significant others getting the information and assistance necessary for them to be effective supports while allowing the person to pursue his/her personal and recovery goals?
- Are the person's services being coordinated effectively across settings, providers, and agencies?
- Are the supports and services provided reducing risks and improving daily functioning? Are needed emergency services provided on a timely, competent, and respectful basis?
- Are services and results tracked frequently with services modified to reflect changing needs and life circumstances? Are services effective in improving well-being and functioning while reducing risks of harm, restriction, or decompensation?

The CSR provides a close-up way of seeing how individual participants are doing in the areas that matter most. It provides a penetrating view of practice and what is contributing to results.

WHAT'S LEARNED THROUGH THE CSR

The CSR involves case reviews, observations, and interviews with the person and people important to the person. Results provide a rich array of learnings for next-step action and improvement. These include:

- Detailed stories of practice and results in real situations and recurrent patterns observed across persons reviewed.
- Deep understandings of contextual factors that are affecting daily frontline practice in a site or agency being reviewed.
- Quantitative patterns of consumer status and practice performance results, based on key measures.
- Noteworthy accomplishments and success stories.
- Emerging problems, issues, and challenges in current practice situations explained in local context.
- Critical learning and input for next-step actions and for improving program design, practice, and working conditions.
- Repeated measures revealing the degree to which important service system transformation aspirations are being being fulfulled in daily frontline recovery-oriented practice for adult consumers of mental health and addiction services.

INTRODUCTION TO THE CONSUMER SERVICE REVIEW PROTOCOL

GENERAL INFORMATION

Persons using this protocol should have completed the classroom training program (12 hours). Candidate reviewers should be using the protocol in a shadowing/mentoring sequence involving two consecutive case review situations conducted in the field with an inter-rater agreement check made with the second case. The trainee's first case analysis and ratings, feedback session with front-line staff, oral case presentation, and first case write-up should be coached by a qualified mentor. With the recommendation of the mentor, trainees who have successfully completed these steps will be granted review privileges on a review team under the supervision of the team leader and the case judge who approves written reports. Trainees may be certified after three successful reviews and successfully meeting the rating standards set by the expert review panel on the certification simulation. Any other users of this protocol should be certified reviewers. Users of this protocol should remember the following points:

- The case review made using this protocol is a *professional appraisal* of the: (1) status of a person on key indicators; (2) recent progress made on applicable change indicators; and (3) adequacy of performance of essential service functions for that person. Each person served is a unique and valid point-in-time "test" of frontline practice performance in a local system of care.

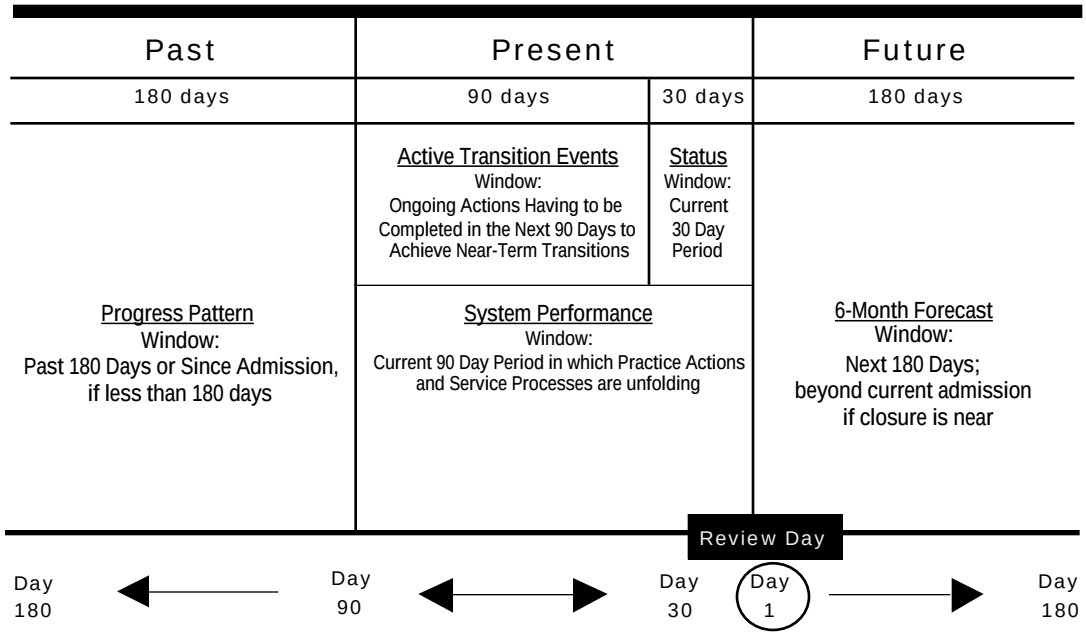
- Reviewers are expected to use *sound professional judgment, critical discernment of practice*, and *due professional care* in applying case review methods using this protocol and in developing status, recent progress, and practice performance findings. Conclusions should be based on objective evaluation of pertinent evidence gathered during the review.

- Reviewers are to apply the following timeframes when making ratings for indicators: (1) person status ratings should reflect the dominant pattern found over the past 30 days; (2) progress pattern ratings on applicable items should reflect change occurring over the past 180 days (or since admission if less than 180 days); and (3) service system practice and performance item ratings should reflect the dominant pattern/flow over the past 90 days. [See display provided below.]

- Apply the *6-point rating scale* for status, progress and practice performance for each examination. Mark the appropriate ratings in the protocol, then transfer the ratings to the CSR Profile Sheet also referred to as the "roll-up sheet."

- IT IS IMPERATIVE THAT REVIEWERS "CALL IT AS THEY SEE IT" and reflect their *honest and informed appraisals* in their ratings and report summary. When a reviewer mentions a concern about a participant in the oral debriefing, that same problem should be reflected in the reviewer's ratings in the protocol examination booklet and noted in the written summary.

Timeframes of Interest in Case Reviews



INTRODUCTION TO THE CONSUMER SERVICE REVIEW PROTOCOL

- Report any *risks of harm* or possible abuse/neglect to the review team leader immediately. The reviewer and team leader will identify appropriate authorities and report the situation.

- If, while reviewing the case record material and conducting the interviews, the reviewer determines the *need to interview an individual not on the review schedule*, the reviewer should request that the interview be arranged, if possible. It may be possible to arrange a telephone interview when a face-to-face interview cannot be made.

- *Before beginning your interviews*, read the participant's service plan(s); any psychological, psychiatric; court documents; and recorded progress notes for at least the past 90 days. Make notes for yourself of any questions you have from your record review, and obtain the answers during your interviews from the relevant person(s). You may have questions that need to be answered by the case manager/care coordinator before you begin your interviews.

- Gather information for the *demographic section* of the protocol from the case manager and records. Be sure to note medications; diagnoses; and any chronic health, mental health, or behavioral problems that require special care.

- Thoroughly complete the *examination section* of the protocol. Be sure each summative question rating matches the rating you enter on the CSR Profile Sheet.

- The *written case summary* in the protocol should be organized by section and submitted electronically. Please write in complete sentences. Do not use proper names. For example, use "the person" instead of "Mary", "the case manager" instead of "Ms. Smith." If you rate any examination as inadequate (i.e., rating of 1-3), please explain this in the written summary. Use the case write-up section as the structure for presenting your cases during the oral debriefing.

- The completed *Profile Sheet* and the *Agreement Check* for the case assigned to the reviewer MUST be given to the review team leader at the announced day and time so that the information can be used to "roll-up" results for the sample and site. Check the review schedule for the week to determine when these items are due to the team leader. If the reviewer is directed to fax the roll-up sheet(s) to HSO for processing, the fax number to be used is 850/422-8487.

- The *written case summary* MUST be returned to the CSR Coordinator not later than the Friday of the week following the field-work activities. The report should be be emailed. Also, turn in the interview schedule for each case. Please indicate on the schedule if a planned interview was not done and the reason; for example, cancellation, no-show, could not find the location.

RATING SCALE LOGIC

The general rating scale logic is displayed in the graphic on the next page.

ORGANIZATION OF THIS PROTOCOL BOOKLET

This protocol booklet is organized into the following sections:

- **Introduction**: This first section of the protocol provides a basic explanation of the review process and protocol design.

- **Person Status Indicators**: The second section provides the 12 status indicators used in the review.

- **Progress Indicators**: The third section provides nine progress indicators used in the review.

- **Practice Performance Indicators**: The fourth section provides fourteen practice indicators used in the review.

- **Overall Patterns**: The fifth section provides the working papers that the reviewer uses to determine the overall patterns for the person domain, progress domain, and practice performance domain. In addition, this section includes the instructions for making the six-month forecast.

- **Reporting Outlines**: The sixth section provides the outlines that reviewers are to use in developing and presenting the ten-minute oral summary of case findings and the written summary report to be submitted following the review.

- **Appendices:**

  1) **Advance Information Packet**: This section provides an advance packet of information about the person and their service situation that is completed by the care coordinator, case manager, or therapist responsible for coordinating services for this individual. This information is prepared in advance of the onsite review and provided to the reviewer to use when beginning the CSR process.

  2) **CSR Data Profile or "Roll-Up Sheet:"** This section provides a copy of the roll-up sheet to be completed and submitted by the reviewer for each case reviewed.

CSR Interpretative Guide for Consumer Status

Maintenance Zone: 5-6

Status is favorable. Efforts should be made to maintain and build upon a positive situation.

6 = **OPTIMAL STATUS**. The best or most favorable status presently attainable for this person in this area [taking age and ability into account]. The person doing great! Confidence is high that long-term goals or expectations will be met in this area.

5 = **GOOD STATUS**. Substantially and dependably positive status for the person in this area with an ongoing positive pattern. This status level is consistent with attainment of long-term goals in area. Status is "looking good" and likely to continue.

Acceptable Range: 4-6

Refinement Zone: 3-4

Status is minimum or marginal, may be unstable. Further efforts are necessary to refine the situation.

4 = **FAIR STATUS**. Status is minimally or temporarily sufficient for the person to meet short-term objectives in this area. Status is minimally acceptable at this point in time, but may be short-term due to changing circumstance, requiring change soon.

3 = **MARGINAL STATUS**. Status is marginal or mixed and not quite sufficient to meet the person's short-term objectives now in this area. Status now is not quite enough for the person to be satisfactory today or successful in the near-term. Risks are minimal.

Improvement Zone: 1-2

Status is now problematic or risky. Quick action should be taken to improve the situation.

2 = **POOR STATUS**. Status continues to be poor and unacceptable. The person seems to be "stuck" or "lost" and status is not improving. Risks are mild to moderate.

1 = **ADVERSE STATUS**. The person's status in this area is poor and getting worse. Risks of harm, restriction, separation, regression, and/or other poor outcomes are substantial and increasing.

Unacceptable Range: 1-3

CSR Interpretative Guide for Consumer Performance

Maint. - Green Zone: 5-6

Performance is effective. Efforts should be made to maintain and build upon a positive practice situation.

6 = **OPTIMAL PERFORMANCE**. Excellent, consistent, effective practice for this person in this function area. This level of performance is indicative of exemplary practice and results for the person. ["Optimum" does not imply "perfection."]

5 = **GOOD PERFORMANCE**. At this level, the system function is working dependably for this person, under changing conditions and over time. Effectiveness level is consistent with meeting long-term goals for the person. [Keep this going for good results]

Acceptable Range: 4-6

Refine. - Yellow Zone: 3-4

Performance is minimal or marginal and maybe changing. Further efforts are necessary to refine thepractice situation.

4 = **FAIR PERFORMANCE**. This level of performance is minimally or temporarily sufficient for the person to meet short-term objectives. Performance may be time-limited or require adjustment soon due to changing circumstances.[Some refinement is indicated]

3 = **MARGINAL PERFORMANCE**. Practice at this level may be under-powered, inconsistent, or not well-matched to need. Performance is insufficient for the person to meet short-term objectives. [With refinement, this could become acceptable in the near future.]

Improve. - Red Zone: 1-2

Performance is inadequate. Quick action should be taken to improve practice now.

2 = **POOR PERFORMANCE**. Practice at this level is fragmented, inconsistent, lacking in intensity, or off-target. Elements of practice may be noted, but it is incomplete/not operative on a consistent basis.

1 = **ADVERSE PERFORMANCE**. Practice may be absent or not operative. Performance may be missing (not done). - OR - Practice strategies, if occurring in this area, may be contra-indicated or may be performed inappropriately or harmfully.

Unacceptable Range: 1-3

SECTION 2

PERSON'S STATUS

[OVER THE PAST 30 DAYS]

STATUS REVIEW 1: SAFETY

SAFETY: To what degree is this person: 1) Safe from manageable risks of imminent harm in his/her daily settings and activities? 2) Verbally hostile to others in ways that may provoke a physically aggressive reaction by others? 3) Aggressive toward others? 4) Endanger him/herself?

Personal safety is central to one's well-being. The person should be free from known and manageable risks of harm in his/her daily environments. Safety from harm extends to freedom from unreasonable intimidations and fears that may be induced by others, care staff, treatment professionals, or fellow residents. A person who is unsafe from actual injury or who lives in constant fear of assault, exploitation, humiliation, isolation, or deprivation is at risk of injury or death, co-dependent behavior patterns, low self-esteem, and perpetrating similar harm on others. Safety and good health provide the foundation for normal daily living, especially for persons with emotional or behavioral health problems. Safety applies to settings in the person's natural community as well as to any special care or treatment setting in which the person may be served on a temporary basis. Persons in a special care or treatment setting must be free from abuse, neglect, and sexual exploitation. Safety, as used here, refers to adequate management of known risks to the person's physical safety and to the safety of others in all settings. **Safety is relative to known risks**, not an absolute protection from all possible risks to life or physical well-being. All adult supporters and professional interveners in the person's life bear a responsibility for maintaining safety of the person and for others who interact with the person. Protection of a person with self-injurious behaviors and protection of others from a person with assaultive behavior may require special safety precautions.

Determine from Informants, Plans, and Records

Has the treatment team completed a risk assessment of this person to determine any safety risks due to: [based on relevant aspects of case history]

- ☐ **1. Domestic violence?**
- ☐ **2. Physical abuse?**
- ☐ **3. Substance abuse?**
- ☐ **4. Sexual abuse?**
- ☐ **5. Emotional abuse?**
- ☐ **6. Mental illness?**
- ☐ **7. Dangerousness (self-injury, aggression, danger to others)?**
- ☐ **8. Neglect of any physically dependent person in the home?**
- ☐ **9. Other factors?: _____**

If current safety risks require immediate intervention, identify steps taken.

1. Has the person been a victim of abuse, neglect, or exploitation (12 months)?
2. Does the person come from a family that has a history of domestic violence?
3. Does the person have a history of emotional/behavioral problems that have resulted in injury to self or others?
4. Is the person now presenting self-injury or aggression toward others?
5. Has the person exhibited sexually offending behavior?
6. Does the person have a pattern of frequent injuries or victimization?
7. Does the person have any co-occurring conditions?
8. Does substance abuse or addiction place this person at risk?
9. Does the person share needles? Have unprotected sex?
10. Does the person require a high level of support? Does he/she get it?
11. What supports and safety plans are in place to protect this person?

Facts Used in Rating Status

NOTE:

Consider patterns reported in records and by informants over the past 12 months to form a risk context for the person. But, rate the person's current safety status over the past 30 days, based on the information gathered. If safety plans exist for this person, are those plans working in prevention of injury or harm?

STATUS REVIEW 1: SAFETY

Determine from Informants, Plans, and Records	Facts Used in Rating Status
12. Has the person required special intervention due to behavior/law violations? Does the person engage in high risk activities? 13. Has there been an allegation of abuse, neglect, or exploitation of this person in the past 12 months? Was a referral made to the police or Adult Protective Services? 14. Are family caregivers, if present for this person, aware of risks to the person? Are known risks being managed effectively for this person?	*Consider the steps that practitioners and service staff have made in addressing any of these concerns.*

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- Situation indicates **optimal safety** for all persons in all of this person's daily settings. The person has a very safe living situation, with highly reliable and competent service providers as necessary, and is safe in the major daytime activity setting, is free from intimidation, and presents no safety risks to self or others. The person is considered very safe from known and manageable risks of harm and is fully free of unreasonable intimidation or fears at home and school/work/daytime activity.

  6 Person | Others

- Situation indicates **good safety** for the person in his/her daily settings and for others near this person. The person has a generally safe living situation, with substantially reliable and competent caregivers as necessary, and is substantially safe in the major daytime activity setting, is free from intimidation, and presents no safety risks to self or others. The person is considered generally safe from known and manageable risks of harm and is substantially free of unreasonable intimidation or fears at home and school/work/daytime activity.

  5 Person | Others

- Situation indicates **fair safety** from imminent risk of physical harm for the person in his/her living and learning settings and for others who interact with this person. The person has a minimally safe living arrangement, with any present caregivers, is usually safe in the major daytime activity setting, has limited exposure to intimidation, and presents no more than a minimal safety risk to self or others. The person is considered minimally safe from known and manageable risks of harm at home and school/work/daytime activity.

  4 Person | Others

- Situation indicates **a minor safety issue present in at least one setting** that poses an elevated risk of physical harm for the person in his/her living and daily activity settings and for others who interact with this person. The person's living arrangement may require active intervention or supportive services. **- OR -** The person may mildly injure self or others rarely. **- OR -** Persons at home or in the person's major daytime setting may pose a safety problem for this person.

  3 Person | Others

- Situation indicates **substantial and continuing safety problems** that pose elevated risks of physical harm for this person in his/her living and daytime activity settings and for others who interact with this person. The person's living arrangement may require protective intervention or specialized services. **- OR -** The person may injure self or others occasionally. **- OR -** Persons at home or in the person's major daytime setting may pose a serious safety problem for this person.

  2 Person | Others

- Situation indicates **adverse and worsening safety problems** that pose high risks of physical harm for the person in his/her daily settings and for others. The person may require protective intervention or intensive services to prevent injury to self or others. **- OR -** The person may seriously injure self or others. **- OR -** Persons in his/her current daily settings may have abused, neglected, or exploited this person.

  1 Person | Others

- **Not Applicable** The person is not a danger to others who interact with this person.

  NA Others

STATUS REVIEW 2: INCOME ADEQUACY & PERSONAL CONTROL

INCOME & CONTROL: To what degree: • Are the person's earned income and economic supports adequate to cover basic living requirements (i.e., shelter, food, clothing, transportation, health care/medicine, leisure, child care)? • Is this person accessing, receiving, and controlling the economic benefits to which he/she is entitled? • Does the person have economic security sufficient for maintaining stability and for effective future life planning?

Adults aspire to have adequate income and personal control over their finances. Income may be earned and also may come from other sources. A person with a serious and persistent mental illness may earn income and/or be entitled to a variety of economic benefits and sources of income. Among these are Supplemental Security Income (SSI or SSDI, SSDAC, VA), Medicaid, HUD housing subsidy, food stamps, subsidized child care, Temporary Assistance to Needy Families (TANF), and possibly other economic supports, depending on eligibility and need. Such economic supports are intended to cover basic living requirements and other necessities for daily living, child care (as appropriate), and competitive, integrated employment (a setting typically found in the community in which individuals with disabilities interact with non-disabled individuals). Together, these sources of income and support should provide a level of economic security that enables a person to achieve and maintain a reasonable degree of stability in his/her living situation. Stability in income, housing, nutrition, and health care provides a foundation for effective future life planning for the person.

A person living with mental illness may require assistance from knowledgeable persons in securing benefits to which he/she is entitled. Such assistance may be provided by a case manager or social worker via a helping agency serving the person. General expectations in this review concerning the status of the person and practice in his/her case are that: (1) to the greatest extent possible, the person is earning income and controlling his/her assets; (2) the person has been/is being assisted in accessing all sources of income and economic security to which the person is entitled, (3) follow-up activities are conducted to ensure that the person is continuing to access the full array of benefits to which the person is entitled, (4) assessments are made to determine that economic supports are adequate to cover the person's basic living requirements, (5) advocacy is undertaken to address any important unmet needs, and (6) the person has a reasonable degree of economic security sufficient to achieve and maintain stability in conditions of daily living. The focus in this review is placed on the person's current status of income adequacy to meet needs and degree of control over his/her money and other assets.

Determine from Informants, Plans, and Records

1. What are this person's basic living requirements (e.g., shelter, food, clothing, health care, medications) and other necessities of daily living (e.g., transportation, child care, education, or employment-related necessities)?

2. Does this person have dependent children in his/her care? What is this person's current earned income? For what types of economic assistance is this person/family eligible? What other agencies are involved in providing services and supports to this person/family? What economic assistance is being provided by other agencies?

3. To what extent are the person's basic living requirements, medications, and other necessities known and understood by the case manager, therapist, or counselor who is coordinating services for this person? What assessment, follow-up, and advocacy has the staff done on behalf of this person?

4. How effective are current efforts in securing the economic and support resources for meeting this person's basic living requirements and other necessities of daily living? Does this person have what he/she needs to get by?

5. Does this person have a degree of economic security sufficient to achieve and maintain stability in conditions of daily living for him/herself and for any minor children in his/her care?

Facts Used in Rating Status

Does this person have a GUARDIAN?

If so, is it a full or limited guardianship?

Who is the principal payee for SSI or other cash assistance?

Does the person know how much is received?

Who accounts for these funds?

Is the person moving toward a greater degree of self-management of funds?

STATUS REVIEW 2: INCOME ADEQUACY & PERSONAL CONTROL

Determine from Informants, Plans, and Records	Facts Used in Rating Status
6. Has this person lost housing, child custody, or employment due to the lack of income or the ability to meet basic living requirements or other necessities of daily living?	
7. What steps are being taken, if necessary, to prevent future disruptions (e.g., eviction) and/or to achieve stable living conditions for this person/family?	
8. If continued instability is present, is it caused by unresolved income and economic security issues? If so, what steps are being taken to resolve these matters (e.g., creative assistance in managing limited funds)?	

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Income Adequacy & Control**. The person is earning income and/or accessing and receiving all benefits to which he/she is entitled. Income and economic supports are sufficient to cover basic living requirements and other necessities. The level of economic security is excellent when the amount and source of funds are considered. There is no recent history of loss of income or benefits. The person may control funds. — **6** ☐

- **Good Income Adequacy & Control**. The person is earning income and/or accessing and receiving most economic benefits to which he/she is entitled. Income and economic supports are generally sufficient to cover basic living requirements for the most part or except in extreme emergencies. The level of economic security is sufficient for maintaining stability. The person may control most of the funds most of the time. — **5** ☐

- **Fair Income Adequacy & Control.** The person is earning income and/or accessing and receiving some economic benefits to which he/she is entitled. Income and economic supports are minimally sufficient to cover basic living requirements and other necessities of daily living. The level of economic security is minimal for maintaining stability. The person may control some of the funds at least some of the time. — **4** ☐

- **Marginal Income Adequacy & Control.** The person is earning limited income and/or accessing and receiving limited economic benefits to which he/she is entitled. Income and economic supports are somewhat inadequate in meeting basic living requirements and other necessities of daily living. The level of economic security is not sufficient for maintaining stability. Economic inadequacies causing disruptions may have occurred in the recent past and the risk of future disruption may be present. Causes of economic disruption are known, but solutions have not been found. The person may have limited control over funds. — **3** ☐

- **Poor Income Adequacy & Control.** The person has substantial problems of economic security and is not receiving the range of economic benefits to which he/she is entitled. Current economic security is insufficient for maintaining stability. Causes of economic disruption are known and present but are not adequately or realistically addressed in current plans or remedial actions are not being implemented on a timely and competent basis. The person may have little, if any, control over even a small portion of the funds. — **2** ☐

- **Adverse Income Adequacy & Control.** The person has serious and worsening problems of economic security. Because he/she is not receiving entitled benefits, the person is experiencing serious but avoidable hardships and life disruptions (e.g., eviction, loss of children, unemployment). Life disruptions may be continuing. Causes of economic disruption may be complex or not adequately understood or not realistically addressed with current casework or supportive services at this time. The person has no control over any of the funds. — **1** ☐

STATUS REVIEW 3: LIVING ARRANGEMENTS

LIVING ARRANGEMENTS: • Is this person living in a home that he/she chose, with supports that are necessary and sufficient for safe and successful pursuit of recovery? • If not, is this person residing in a community living arrangement that is necessary to meet the person's therapeutic and recovery needs? • Are the person's culture, language, and living and housemate preferences addressed in an appropriate and supportive manner, consistent with his/her recovery goals?

The person should be living in an adequate home of his/her choice and with persons of his/her choice. This may be a personal home, a supported living arrangement (three or fewer beds), or the home of a significant other. Any needed supports in the home should provide for safe and successful daily living for the person. Because of particular treatment or support needs, some persons may be residing temporarily in a group living setting. The group residential situation should be consistent with the person's language and culture and provide any supports and services necessary for success in that setting. When in a group residential setting, the following matters should be taken into account when reviewing living arrangements. Whether the group living arrangement affords the person: (1) safe and sanitary living and activity areas; (2) adequate living space; (3) appropriate grouping patterns; (4) balanced and nutritionally adequate meals; (5) hygiene (including personal hygiene articles, bathing schedule that promotes privacy, opportunity to bathe daily or more often if needed); (6) privacy, as appropriate to safety; (7) personal possessions, as appropriate to safety; (8) dignity and respect from staff; and (9) freedom of movement (coming and going), as appropriate to safety.

Determine from Informants, Plans, and Records

1. What is the person's current living arrangement? Is the person living in a home of his/her choice and with persons of his/her choice? Who else is living in the person's current home? Can the person's friends visit the person in the home?

2. Does the person's home provide necessary supports and services for safe and successful living? How long has the person lived there? Is it a stable placement?

3. How well does the person's current living arrangement fit his/her language, culture, and personal preferences?

4. Is the person presently residing in a group setting? If so, consider whether the group living arrangements provide:

   - Safe and sanitary living and activity areas?
   - Adequate living space (versus overcrowding)?
   - Appropriate grouping patterns (age, gender, functional level, language)?
   - Balanced and nutritionally adequate meals?
   - Adequate hygiene opportunities and supports (including personal hygiene articles, bathing schedule that promotes privacy, opportunity to bathe daily or more often if needed)?
   - Privacy, as appropriate to safety?
   - Personal possessions, as appropriate to safety?
   - Dignity and respect from staff?
   - Freedom of movement?

5. Does the counselor/case manager/therapist recognize whether current living arrangements are appropriate and adequate for this person?

6. If the person is homeless and without shelter, what outreach, engagement, and assertive community treatment strategies are being used to get the person into appropriate housing or treatment?

Facts Used in Rating Status

Person's current living setting:

- ☐ *Personal home, with supports as needed*
- ☐ *Home of family or friend*
- ☐ *Supported living arrangement*
- ☐ *Adult boarding home*
- ☐ *Group home/step-down home*
- ☐ *Residential treatment facility*
- ☐ *Hospital/inpatient facility*
- ☐ *Secure facility/jail*
- ☐ *Shelter (homeless/DV shelter)*
- ☐ *Homeless/street life*

STATUS REVIEW 3: LIVING ARRANGEMENTS

Determine from Informants, Plans, and Records	Facts Used in Rating Status
7. If the person is in jail, what services are being offered?	
8. If the person is in a hospital, are staff assisting with discharge planning?	

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Living Arrangement.** This person is living in his/her own home or in a friend's, partner's, or family caregiver's home with excellent supports that are necessary and fully sufficient for safe and successful daily living. **- OR -** This person is currently residing in a small community living arrangement that is consistent with the person's culture, language, and living preferences and provides excellent supports for the pursuit of recovery. **- OR -** The person is temporarily living in a group facility that is the least restrictive, most appropriate setting to meet the person's treatment needs or life situation requirements. This residential facility meets all criteria (see item 4 on page 14) at an optimal, consistent level for this person. — **6** ☐

- **Good Living Arrangement.** This person is living in his/her own home or in a friend's, partner's, or family caregiver's home with good supports that are necessary and generally sufficient for safe and successful daily living. **- OR -** This person is currently residing in a small, generally appropriate community living arrangement that is substantially consistent with the person's culture, language, and living preferences and provides good supports for the pursuit of recovery. **- OR -** The person is temporarily living in a group facility that is the least restrictive, generally appropriate setting to meet the person's treatment needs or life situation requirements. This facility substantially meets the criteria (see item 4 on page 14) for this person. — **5** ☐

- **Fair Living Arrangement.** This person is living in his/her own home or in a friend's, partner's, or family caregiver's home with fair supports that are minimally sufficient for safe and successful daily living. **- OR -** This person is currently residing in a small, minimally appropriate community living arrangement that is fairly consistent with the person's culture, language, and living preferences and provides minimally adequate supports for the pursuit of recovery. **- OR -** The person is temporarily living in a group facility that is a less restrictive, fairly appropriate setting to meet the person's treatment needs or life situation requirements. This facility minimally meets criteria (see item 4 on page 14) for this person. — **4** ☐

- **Marginal Living Arrangement.** This person is living in his/her own home or in a friend's, partner's, or family caregiver's home with limited or inconsistent supports that are marginally sufficient for the pursuit of recovery. **- OR -** This person is currently residing in a small, marginally appropriate community living arrangement that is limited in consistency with the person's culture, language, and living preferences and provides inconsistent supports for the pursuit of recovery. **- OR -** The person is temporarily living in a group facility that is a somewhat more restrictive, less appropriate setting for the person's treatment needs or life situation requirements. This facility marginally meets some criteria (see item 4 on page 14). Some risks of harm may be present. — **3** ☐

- **Poor Living Arrangement.** This person is living in a situation that is not sufficient for safe and successful daily living. The situation could be jail, shelter, or homelessness. **- OR -** The person is temporarily living in a group facility that is unnecessarily restrictive or inappropriate for the person's treatment needs or life situation requirements. This facility meets few criteria (see item 4 on page 14) for this person. Risks of harm for this person are substantial. — **2** ☐

- **Adverse Living Arrangement.** This person is living in a situation that is unsafe and detrimental to the person's functioning and well-being. The situation could be jail, a crackhouse, or homeless street life. **- OR -** The person is temporarily living in a group facility that is highly restrictive and/or grossly inappropriate for the person's treatment needs or life situation requirements. Conditions in this facility are adverse for care, dignity, and recovery. Risks of harm for this person are high or worsening. — **1** ☐

STATUS REVIEW 4: SOCIAL NETWORK

SOCIAL NETWORK: To what degree:• Is this person connected to a support network of family, friends, and peers, consistent with his/her choices and preferences? • Is this person provided access to peer support and community activities? • Does this person have opportunities to meet people outside of the service provider organization and to spend time with them? • Does the social network support recovery efforts?

As a social species, human beings seek, value, and maintain relationships with others, often for a lifetime. Affiliation gives one's life identity, purpose, and connections. Community is the place where we meet and join with others in life's meaningful activities. Interactions with others provides a sense of belonging and social participation. The focus here is placed upon the person's social connections and natural supports and the extent to which he/she is provided access to peer support and community activities. Because a person with a mental illness may rely on service providers for assistance necessary to maintain existing positive social connections and develop new ones, concern is placed on having opportunities to meet and get to know people outside the service provider organization. Where the person may require encouragement, supports, and structured opportunities to form and maintain social connections with friends, family, co-workers, and others in the community, how well is the service provider meeting the support requirements? Two essential components of the social network are the size of the person's network (or number of family, friend, work, school, etc. ties) and the extent the person's social network actively supports or discourages recovery efforts.

Determine from Informants, Plans, and Records

1. How well is this person connected to a natural support network consisting of family, friends, and peers? What is the overall size of the support network? Is the network supportive of recovery activities?
    - Which family members are part of this person's support network?
    - Which friends (outside the provider agency and service population) are part of this person's support network?
    - Which peers does this person see on a regular basis?
2. Does this person have friends and opportunities to interact with other members of the community in positive ways, subject to his/her preferences?
3. Is this person connected with a local faith community (e.g., church, synagogue, mosque) or with other ways of meeting his/her spiritual needs? Does the person have transportation to and from church-related activities?
4. What kinds of peer support and community activities are provided to this person? To what degree does this person accept and use the peer support and community activities that are currently provided?
5. What specific goals and strategies contained within the person's recovery plan are directed toward improving social connections and supports for this person?
6. What effect are any goals and strategies directed toward improving the person's social connections and supports having? What strategies or activities have worked in the past for this person?
7. Does this person have an informal support person who helps in times of crisis? Does this person have an advance directive to guide helpers in times of crisis?
8. Does this person experience negative influences or effects from persons in his/her social network? What steps are being taken to minimize any problems?
9. What are the characteristics of the person's social network? Is the network actively engaged in /or supportive of recovery efforts?

Facts Used in Rating Status

NOTE:

Consider the size and composition of the person's current social network:

- *Number of age-peer friends:* _____
- *Number of friends who do not have a disabling condition:* _____
- *Number of relatives with close and supportive relationships:* _____
- *Number of paid persons (e.g., trainer, therapist, aide, case manager) who have close, supportive relationships:* _____
- *Number of non-related, non-paid adults who have a close and supportive relationship with this person:* _____

Consider the duration of the relationships. How many have endured for more than a year? ___

Consider the supportive quality of those relationships. How many actually provide positive guidance, direction, support, and friendship for the person? _____

Consider the significance of the relationship to the person. Which of these persons does he/she feel particularly close to, finding attachment and security in the relationship? _____

STATUS REVIEW 4: SOCIAL NETWORK

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Social Network/Positive Support.** This person has a wide, substantial, and continuing social support network. It may consist of many friends, family, and/or peers. Forming and maintaining this social network may be the result of excellent access to peer support and community activities offered by provider agencies. He/she may have many ongoing opportunities to meet people outside of the service provider organization and to spend time with them. The network actively supports the person's recovery goals and provides positive ties for treatment and participation of both leisure activities and routine care.

6
☐ Network comp.
☐ Recovery support

- **Good Social Network/Good Support.** This person has a meaningful and dependable social support network. It may consist of friends, family, and/or peers. Forming and maintaining this social network may be the result of good access to peer support and community activities offered by provider agencies. He/she may have regular ongoing opportunities to meet people outside of the service provider organization and to spend time with them. Overall, the person's network provides good solid support for social and recovery goals.

5
☐ Network comp.
☐ Recovery support

- **Fair Social Network/Good Support.** This person has a small or minimal social support network. It may consist of some friends, family, and/or peers. Forming and maintaining this social network may be the result of minimally adequate access to peer support and community activities offered by provider agencies. He/she may have occasional opportunities to meet people outside of the service provider organization and to spend time with them. The network offers some support for social and recovery goals.

4
☐ Network comp.
☐ Recovery support

- **Marginal Social Network/Mixed Support.** This person has a limited or inconsistent social support network. It may consist of a few friends, family, and/or acquaintances. Forming and maintaining this social network may reflect marginal access to peer support and community activities offered by provider agencies or to limited interest by the person. He/she may have few opportunities to meet people outside of the service provider organization and to spend time with them. Individuals in the social network neither support or discourage recovery goals. The network may provide some positive and some negative influences from members. **- OR -** The network as a whole is not involved at a level that will sustain social and recovery goals.

3
☐ Network comp.
☐ Recovery support

- **Poor Social Network/Inadequate Support.** This person has a social support network that consist of limited or inconsistent contact with friends, family, and/or acquaintances. Forming and maintaining this social network may reflect poor access to peer support and community activities offered by provider agencies or to the person's preferences. He/she may have rare opportunities to meet people outside of the service provider organization and to spend time with them. **- OR -** He/she may occasionally form acquaintances around risky or harmful activities. The person's network rarely supports treatment or recovery goals.

2
☐ Network comp.
☐ Recovery support

- **Absent Social Network/Absent Support.** This person has no or very few ties to a support network. The person may have acquaintances who engage or join the person in risky or harmful activities. Absence of a network support or only the presence of negative ties may reflect lack of access to peer support and community activities offered by provider agencies or to the person's preferences. He/she may have no opportunities to meet positive people outside of the service provider organization and to spend time with them. **- OR -** The person may have ongoing acquaintance patterns which result in risky or illegal activities with individuals that discourage participation in treatment and derail recovery efforts.

1
☐ Network comp.
☐ Recovery support

STATUS REVIEW 5: SATISFACTION WITH SERVICES

SATISFACTION WITH SERVICES: To what extent is the person satisfied with the treatment, support services, respect, and recovery progress that he/she is presently experiencing?

Satisfaction is a concern of the person who is the focus of review. If the person lives with a family member or others who provide assistance to the person and who may receive support services in the home, then that person's views are solicited also. If the person is being served temporarily in a residential treatment setting or hospital and will be returning home, then the views of any spouse, family member, or significant other with whom the person will be residing is solicited. Satisfaction is concerned with the degree to which the person receiving services believes that those services are appropriate for his/her needs; respectful of his/her views and privacy; convenient to receive; tolerable (if imposed by court order); pleasing (if voluntarily chosen); and, ultimately, beneficial in effect. Satisfaction extends to:

- **Participation (e.g., having role, voice, choice)** in decisions and plans made for the benefit of the person.
- Having **trust-based relationships** with persons involved in the person's care, treatment, and support services.
- Feelings of **respect** for his/her views, ambitions, preferences, and culture in the planning and delivery of services.
- Belief that a **good mix and match** of supports and services is offered that well fits his/her situation.
- Appreciation for the **quality/dependability** of assistance and support provided.
- Feelings that circumstances are better now than before or are **getting better** because of the supports and services.

The person should be generally satisfied with services, taking into account that services may not always be voluntary.

Determine from Informants, Plans, and Records	Facts Used in Rating Status
1. Does the person now reside with his/her family or a domestic partner?	
2. Is the person living at home? Or living with family members?	
3. Is the person involved with the criminal justice system or homeless system?	
4. Are any of the current services required for conditional release or probation?	
5. Does the person agree with the purpose and type of services received?	
6. Does the person believe that services reflect his/her ambitions, preferences, and culture?	
7. Where appropriate, does any home caregiver (e.g., parent, family member, spouse, domestic partner) agree with the purposes and types of support services received in the home?	
8. Does the home caregiver believe that services reflect his/her views?	
9. Do services received really match the needs of this person? Were these needs determined by the person rather than by others? Are these needs addressed?	
10. Are services provided at convenient times and places?	
11. Does the person believe that he/she is benefiting from these services?	

STATUS REVIEW 5: SATISFACTION WITH SERVICES

Determine from Informants, Plans, and Records	Facts Used in Rating Status
12. To what degree is the person satisfied with current and recent services?	
13. To what degree is any family caregiver, spouse, or domestic partner satisfied with supportive services provided for successful living arrangements?	

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person and Possible Caregiver in the Home — Rating Level

- The respondent reports **optimal satisfaction** with current supports and services. Service quality, fit, dependability, and results being achieved presently exceed a high level of consumer expectation. The respondent "couldn't be more pleased" with the service situation and his/her recent experiences and interactions with service personnel.

  6 — Person | Caregiver

- The respondent reports **substantial satisfaction** with current supports and services. Service quality, fit, dependability, and results being achieved generally meet a moderate level of consumer expectation. The respondent is "generally satisfied" with the service situation and his/her recent experiences and interactions with service personnel. Any complaints and disappointments are minimal.

  5 — Person | Caregiver

- The respondent reports **minimal-to-fair satisfaction** with current supports and services. Service quality, fit, dependability, and results being achieved minimally meet a low-to-moderate level of consumer expectation. The respondent is "more satisfied than disappointed" with the service situation and his/her recent experiences and interactions with service personnel. Any complaints and disappointments are occasional and/or minor.

  4 — Person | Caregiver

- The respondent reports **mild dissatisfaction** with current supports and services. Service quality, fit, dependability, and results being achieved barely meet a low-to-moderate level of consumer expectation. The respondent is "a little more disappointed than pleased" with the service situation and his/her recent experiences and interactions with service personnel. Any complaints and disappointments are recent and substantive.

  3 — Person | Caregiver

- The respondent reports **moderate and continuing dissatisfaction** with current supports and services. Service quality, fit, dependability, and results achieved seldom, if ever, meet a low-to-moderate level of consumer expectation. The respondent is "consistently disappointed" with the service situation and his/her recent experiences and interactions with service personnel. Any complaints and disappointments are substantial and continuing over time.

  2 — Person | Caregiver

- The respondent reports **substantial and growing dissatisfaction** with current supports and services. Service quality, fit, dependability, and results fail to meet any reasonable level of consumer expectation. The respondent is "greatly and increasingly disappointed" with the service situation and his/her recent experiences and interactions with service personnel. Complaints and disappointments may be longstanding, significant, and may be increasing in their scope and intensity.

  1 — Person | Caregiver

- **No Response**. The person declined to offer an opinion or was not able to offer an opinion at this time. - OR - The person does not have a caregiver and the indicator is NA for cargiver.

  NR — Person | Caregiver

STATUS REVIEW 6: HEALTH/PHYSICAL WELL-BEING

HEALTH/PHYSICAL WELL-BEING: • Is this person in the best attainable health*? • Are the person's basic physical needs being met? • Does the person have access to and benefit from health care services, as needed?

Persons should achieve and maintain their best attainable health status, consistent with their age and general physical condition. Health maintenance requires that **basic physical needs** for proper nutrition, clothing, shelter, and personal care are met on a daily basis. Proper **medical and dental care** (preventive, acute, chronic) are necessary for maintaining good health. Preventive health care should include immunizations, dental hygiene, and screening for possible physical problems (e.g., PSA, PAP, TB, mammogram). Physical well-being encompasses both the person's physical health status and access to timely health services.

Persons who are elderly or who have chronic or progressive conditions requiring special care or treatment should have a level of attention commensurate with that required to maintain their best attainable health status. Special care requirements may include nursing, physical therapy, adaptive equipment, therapeutic devices, and treatments (e.g., medications, respiratory treatment). Delivery of these services may be necessary in the person's daily settings. The **central concern** here is that the person's physical needs are met and that special care requirements are provided as necessary to achieve and maintain good health status. Family members, home providers, and professional interveners in the person's life bear a responsibility for ensuring that basic physical needs are being met and that health risks, chronic health conditions (e.g., COPD, HIV, diabetes) and acute illnesses are adequately addressed in a timely manner. Health concerns expressed by the person should be taken seriously and evaluated.

Determine from Informants, Plans, and Records

1. Are the person's needs for food, shelter, clothing, and health care met?
2. Is the person a victim of recent neglect, abuse, or exploitation?
3. Is the person diagnosed with a life-threatening disease (e.g., cancer, diabetes, HIV, TB, or hepatitis C)? If yes, what stage of the disease is the person in at this time? What course of treatment is provided or indicated?
4. Does the person have a developmental or physical disability?
5. Does the person appear to have adequate nutrition and physical care?
6. Is the person significantly underweight or overweight?
7. Does the person have frequent colds, infections, or injuries?
8. Does the person have a history of major recurrent health problems?
9. Does the person have a PCP and regular medical check-ups and screenings?
10. Does the person have regular dental care?
11. Are the person's immunizations up to date (e.g., tetanus, flu, hepatitis A-B)?
12. Does the person have prompt access to acute care, when needed?
13. Does the person have continuous access to care and treatment of chronic conditions, if needed?
14. If the person requires special care or treatment for a health condition, are the required services and equipment provided where it is needed by the person?
15. Are health care professionals available to provide education and skills for managing a disease or chronic conditions (e.g., diabetes, hypertension, seizures)?

Facts Used in Rating Status

NOTES:

** The person should be experiencing his/her best attainable health status taking, age and any chronic condition or life-threatening diagnosis into account. Even at the end-stage of a terminal illness, the person may have adequate physical care and nutrition, and benefit from excellent palliative health services provided via hospice.*

Consider whether the person presents risk factors for disease, disability, or premature death. Such factors may include: heavy tobacco use, substance abuse, tardive dyskinesia, medication side effects, obesity, unsafe sex, lack of family planning, and other high risk behaviors (e.g., sharing needles).

Consider whether the person has access to "wellness" choices (e.g., good diet and exercise) for a positive and healthful lifestyle.

Take the person's age and existing health conditions into account when conducting this review.

STATUS REVIEW 6: HEALTH/PHYSICAL WELL-BEING

Determine from Informants, Plans, and Records

16. If the person takes medications for chronic health problems, seizures, or behavior control: Does the person self-medicate? Are medications monitored for safety and effectiveness at least quarterly by the prescribing physician?

17. Does the person reside in a treatment facility or secure facility?

18. Does the person have a health condition requiring monitoring?

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Health Status.** All of the person's physical needs for food, shelter, and clothing are reliably met on a daily basis. Routine preventive medical (e.g., immunizations, check-ups, and health screening) and dental care are provided on a timely basis. Any acute or chronic health care needs are met on a timely and adequate basis, including necessary follow-ups and required treatments. Height and weight are within normal ranges. The person has no recurrent colds, infections, or injuries. The person's health status is the best attainable. **6** ☐

- **Good Health Status.** The person's physical needs are generally met on a daily basis. The person's status is good. Routine health and dental care are generally provided but not always on schedule. Acute or chronic health care is generally adequate, but follow-ups or required treatments may be missed or delayed occasionally. Height and weight are within normal ranges. The person may have occasional colds, infections, or non-suspicious minor injuries that respond quickly to treatment. **5** ☐

- **Fair Health Status.** The person's physical needs are minimally met on a daily basis. The person's health status is good. Routine health and dental care are minimally provided but not always on schedule. Some immunizations may not have occurred. Acute or chronic health care is generally adequate, but follow-ups or required treatments may be missed or delayed but are not life threatening. Height and weight are within 20% of normal ranges. The person may have frequent colds, infections, or non-suspicious minor injuries that respond adequately to treatment. **4** ☐

- **Marginal Health Status.** The person's physical needs for food, shelter, hygiene, or clothing may not be consistently met. The person's nutritional or physical status is problematic. Routine health and dental care may not be adequately provided. Immunizations may not have occurred. Acute or chronic health care may be inadequate and/or follow-ups or required treatments may be missed or delayed but are not immediately life threatening. A serious chronic health problem may not be adequately managed. The person may be underweight or overweight. The person may have frequent colds, infections, or suspicious minor injuries. **3** ☐

- **Poor Health Status.** The person's physical or health care needs are chronically or consistently unmet resulting in ongoing hygiene, nutrition, or health problems that cause the person to suffer from poor health status that is affecting the person's ability to function and perform activities of daily living. Further neglect could lead to physical deterioration or disability. **2** ☐

- **Adverse Health Status.** The person's physical or health care needs are unmet, resulting in ongoing and worsening health problems. These problems are causing the person to suffer from poor and declining health status that is adversely affecting the person's daily functioning. Further neglect could lead to serious physical deterioration, disability, or death. **1** ☐

STATUS REVIEW 7: SUBSTANCE USE

SUBSTANCE USE: • To what degree is the person free from substance use impairment? • If the person is in recovery from a substance use disorder, is the living arrangement atmosphere supportive of recovery efforts?

While any alcohol or substance use is problematic and warrants attention; there are varying degrees and types of substance use resulting in subsequent life impairment. **Substance is defined** as an illicit substance, misuse of over-the-counter medications, misuse of prescribed medications, and/or misuse of chemicals, including misuse of alcohol. Individuals with substance use disorders often have impaired parenting abilities and social skills. Early identification and treatment of substance use disorders will contribute to improved functioning and positive outcomes.

Impairment arising from substance use poses potential harm to physical and emotional well-being. If using substances, the person should be making reasonable progress toward recognizing problems with substance use, increasing motivation to "take charge" of reducing their own substance use, lowering the impairment and risks associated with substance use, and decreasing the use of substances. Recovery efforts may involve active treatment (e.g., medication and/or psycho-social intervention), participation in support groups, changing daily activity patterns and social connections, moving to another area away from sources of addictive substances, and creating an environment (physical and social) that is supportive of recovery efforts. This review focuses on the person's pattern of substance use and reliance on supports for recovery. This indicator is applicable to adults who have histories of substance use impairment. This indicator does not apply to a person who has no history of substance use impairment.

Determine from Informants, Plans, and Records	Facts Used in Rating Status
1. Has the person been screened for substance use disorder?	
2. Is there any alcohol or substance use by the person? If yes, what type of substance is used, what method is used, how often is the substance used, and what are the consequent life problems?	
3. Does the person have a substance use disorder? Is the climate in the home/community supportive of treatment and recovery efforts?	
4. Is the person using substances in isolation, with family, or with a peer group?	
5. Is substance use related to other high risk behavior (needle sharing, sexual activity, DUI, etc.)?	
6. Is substance use causing functional impairment (problems with family, peers, or citizens in the community, or difficulty with employment)? Does the individual recognize the impact of their use/abuse of substance?	
7. Has substance use led to criminal activity or involvement with police or courts?	
8. What level of motivation does the person have for obtaining/maintaining a substance-free lifestyle?	
9. Is the person currently receiving treatment for substance use? Has the person needed and/or received treatment for substance use within the past year?	
10. If treatment for substance use has been received and completed, has relapse presented as a problem? If so, how often? Is relapse prevention being pursued?	

STATUS REVIEW 7: SUBSTANCE USE

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Status**. The person is fully free from substance use impairment at this time. If the person has experienced substance use impairment in the past, the person has maintained sobriety for at least 12 months without relapse. The social climate in the home and support network is fully supportive of recovery efforts. **6** ☐

- **Good Status**. The person is free from substance use impairment at this time. If the person has experienced substance use impairment in the past, the person has maintained sobriety for at least six months without relapse. The social climate in the home and support network is generally supportive of recovery efforts. **5** ☐

- **Fair Status**. The person may have had recent substance use, but impairment is substantially reduced or limited and daily functioning is at a minimally adequate level. The person may be actively participating in an appropriate treatment program. The person may be showing progress in treatment. The social climate in the home and support network is somewhat supportive of recovery efforts. **4** ☐

- **Marginal Status**. The person has mild to moderate substance use impairment that may result in some negative consequences or adversely affects functioning in daily settings. The person may be receiving treatment but may be making little progress. The social climate in the home and support network may not be very supportive of recovery efforts. **3** ☐

- **Poor Status.** The person may have an established pattern of substantial and continuing substance use impairment. The person has moderate to serious substance use that results in very negative consequences and/or substantial functioning limitations. The person may be continuing to use substances and may not be making progress in a treatment program. The social climate in the home may substantially undermine recovery efforts. The person's support network in not functioning or there is no network in place for this person. **2** ☐

- **Adverse Status.** The person has serious and worsening substance use impairment. The person has serious life-threatening substance use patterns that result in significant negative consequences and/or major functional limitations and may cause restriction in an institutional setting. The person's substance use is worsening. The social climate around the person may actively support continued substance use and possibly other illegal activities. **1** ☐

- **Not Applicable.** The person does not have a history of substance use impairment. This indicator does not apply at this time. **NA** ☐

STATUS REVIEW 8: MENTAL HEALTH STATUS

MENTAL HEALTH STATUS: • Is the adult's mental health status currently adequate or improving? • If symptoms of mental illness are present, does the adult have access to mental health care, necessary and sufficient, to reduce symptoms and improve daily functioning?

Mental health status and emotional well-being are essential for adequate functioning in a person's daily life settings. To do well in life, a person should:

- Present an affect pattern appropriate to time, place, person, and situation.
- Have a sense of belonging and affiliation with others rather than being isolated or alienated.
- Socialize with others in various group situations as appropriate to age and ability.
- Be capable of participating in major life activities and decisions that affect him/her.
- Be free of or reducing major clinical symptoms of emotional/behavioral/thought disorders that interfere with daily activities.
- Benefit from continuity of care between health care and mental health service providers, especially when the person has chronic health needs that must be managed concurrent with psychiatric needs.

For a person with mental health needs who requires special care, treatment, rehabilitation, or support in order to make progress toward stable and adequate functioning in daily settings, the person should be receiving necessary services and demonstrating progress toward adequate functioning in most aspects of life. Some persons may require well-coordinated health care and mental health services to be successful. Others may require income assistance or support services. Timely and adequate provision and coordination of supports and services should enable the person to benefit from treatment and make progress toward recovery.

Determine from Informants, Plans, and Service Records

1. Is the person currently presenting psychiatric symptoms or behavioral problems in daily settings? If so, which settings and what are the problems?
2. Does the person receive treatment and rehabilitation services? If so, are symptoms being reduced or managed? Is the person's level of functioning improving? Is the person learning how to cope with troublesome symptoms?
3. Does the person have a serious behavior problem? If so, are maladaptive or high risk behaviors being reduced and replaced with functional behaviors?
4. Does the person present an affect pattern appropriate to time, place, person, and situation? If not, how are mood and/or anxiety problems being addressed?
5. Is the person receiving supportive counseling and, where necessary, special assistance in daily settings consistent with his/her needs for success?
6. Does the person receive medication education? Is this person managing his/her own medications? If so, how reliably?
7. Does this person resist medications? Does he/she present any adverse side effects of medications?
8. Is the person making progress toward recovery? Is the person receiving insight-oriented therapy to build coping skills and life management understandings?
9. Does the person receive services, as necessary, to prevent relapse?
10. Does the person enjoy life and feel connected with others?

Facts Used in Rating Status

NOTE:

Consider whether the person is receiving entitled health and mental health benefits necessary to manage symptoms of mental illness.

Consider whether the person is experiencing distress from symptoms and, if so, whether such symptoms are interfering with the person's work or social situations.

STAGES OF CHANGE:

Five stages of change are defined as:

- *Precontemplation: no intention to change behavior; may be unaware of problems or opportunities.*
- *Contemplation: are aware of problems or opportunities; thinks about acting, upon it but has not made a commitment to take action.*
- *Preparation: combines intention with early behaviors; planning to take action within the next month.*
- *Action: activities are being undertaken to modify behavior and take advantage of opportunities with commitment of time and energy.*
- *Maintenance: person works to make and consolidates gains while acting to prevent relapse or loss; may enter this stage within six months of behavior change.*

STATUS REVIEW 8: MENTAL HEALTH STATUS

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Mental Health Status.** The person is stable and functioning very well across settings. The person may enjoy many positive and enduring supports from a variety of people. He/she may socialize well with others in various group situations, as appropriate, to ability and preferences. He/she may be participating at a high and consistent level in major life activities and decisions that affect him/her. — **6** ☐

- **Good Mental Health Status.** The person is stable and functioning adequately across settings. The person may have some positive and enduring supports from a variety of people. He/she may socialize in generally acceptable ways with others in various group situations, as appropriate to ability and preferences. He/she may be participating at a substantial level in major life activities and decisions that affect him/her. — **5** ☐

- **Fair Mental Health Status.** The person is functioning with no more than expectable reactions to social stressors and no more than slight impairment. The person may have a few positive and enduring supports, mostly from staff or family. He/she may socialize occasionally in at least minimal ways with others in group situations, as appropriate to ability and preferences. He/she may participate at a minimal level in major life activities and decisions that affect him/her. — **4** ☐

- **Marginal Mental Health Status.** The person is functioning with some symptoms or some difficulties in social situations. The person may have a few positive and enduring relationships. He/she may socialize occasionally or marginally with others in group situations, as appropriate to ability and preferences. He/she may be participating at a marginal level in major life activities and decisions that affect him/her. At this level, staff may be working diligently, but may be doing things that don't work for this person. **- OR -** The person has co-occurring alcohol or substance abuse issues that are not well addressed. — **3** ☐

- **Poor Mental Health Status.** The person is functioning with moderate-to-serious symptoms or substantial difficulties in social situations. The person may have a few relationships with rare or unpleasant contacts. He/she may not socialize with others in group situations. He/she may not be participating in major life activities and decisions that affect him/her. At this level, staff may be working, but may be doing things that don't work for this person. **- OR -** Efforts may be substantially inconsistent across health and mental health providers. **- OR -** The person has a serious co-occurring alcohol or substance abuse problem that is poorly understood or addressed. — **2** ☐

- **Adverse/Worsening Mental Health Status.** The person is functioning with serious-to-severe impairments and with potentially dangerous symptoms. The person may be socially isolated or withdrawn. He/she may not be capable of participating in major life activities and decisions that affect him/her. The person may be experiencing an absence of appropriate treatment or breakdown in coordination of treatment modalities with no continuity in care by health and mental health providers. **- OR -** The person has a serious co-occurring addiction that undermines other treatment efforts. — **1** ☐

STATUS REVIEW 9: VOICE & ROLE IN DECISIONS

VOICE & ROLE IN DECISIONS: To what degree: • Is this person actively engaged in service decisions? • Does participation enable the person to express to the service team: (1) preferences about where and with whom to live and where to work, (2) choice of daily routines, (3) wishes about how to spend his/her time and money, (4) choice of service providers, and (5) satisfaction/dissatisfaction with services? • If the person is resistant to participation, are reasonable efforts being made to engage him/her and to support his/her participation?

Whose recovery plan is it—the service consumer's, the funders', or the providers' plan? The **person should have a sense of personal ownership (having a role, voice, choices)** in recovery planning and service decision processes. If not, the likelihood of its success is small. Service arrangements are made to benefit the person by helping to create conditions under which he/she can promote personal recovery and succeed in life. Service arrangements should build on the strengths of the person and should reflect his/her strengths, needs, culture, and preferences. If arrangements are not seen as helpful and dependable by the person, services offered are not likely to be beneficial. The socially valued life dreams, ambitions, and peer group interests of the person should be reflected in as goals and choices in the recovery process and supported by providers. The **central concern** of this review is that the person be an **active participant in shaping and directing service arrangements** that impact his/her life. Emphasis is placed on direct and ongoing involvement in all phases of service: assessment, planning, selection of providers, monitoring, modifications, and evaluation. Allowance should be made when services are imposed by court order for the person rather than being voluntary. The person's satisfaction (see Status Indicator 5: Satisfaction) with services may be a useful indicator of participation and ownership. *["Nothing about us without us!"]* If the person is resistant, diligent and appropriate ongoing efforts should be made to encourage participation (see Practice Review 1: Engagement).

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
1. What role does this person have in the recovery planning process? Does he/she have a meaningful voice in shaping service decisions and arrangements?	
2. Does the person know and agree with any personal recovery goals found in service planning documents? Does the person "own" his/her recovery plan and related services? How are the person's strengths and preferences reflected in assessments, plans, and the mix and fit of the services provided?	
3. Does the person demonstrate enthusiasm about his/her interactions and relationships with service providers?	
4. Are service providers comfortable working with the person as a partner?	
5. Is the person comfortable expressing dissatisfaction to service providers? Does the person know what to do if his/her rights are violated?	
6. Does the person routinely participate in the monitoring/modification of his/her recovery plan goals, strategies, arrangements, service and providers? Does the person routinely participate in the evaluation of results?	
7. Has the person invited friends, neighbors, mentors, and other supporters to participate in the recovery planning and service decision processes? Is the service process person-directed and responsive to this person's particular cultural values?	
8. If the person resists participation, what diligent and ongoing efforts have been and are being made to engage the person in the service process?	

STATUS REVIEW 9: VOICE & ROLE IN DECISIONS

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Role and Voice in Decisions.** The person is a full, effective, and ongoing participant in all major aspects of assessment, planning, making service arrangements, selecting providers, monitoring, and evaluating services and results. Special accommodations or supports are offered as needed to assist participation. The person assists in planning personal recovery goals, deciding on services, and shaping the service process to support and achieve life ambitions. **6** ☐

- **Good Role and Voice in Decisions.** The person is a regular, ongoing participant in most aspects of assessment, planning services, making service arrangements, selecting providers, monitoring, and evaluating services and results. Meetings are scheduled at times convenient for the person, when needed. The person participates in planning life goals, major activities, and service arrangements. **5** ☐

- **Fair Role and Voice in Decisions.** The person selectively participates in offering assessment information, planning services, and providing feedback about service satisfaction. The person usually participates in planning personal recovery goals and deciding between attractive and appropriate service options offered. **4** ☐

- **Marginal Role and Voice in Decisions.** The person is notified of recovery team meetings. The person is allowed to attend service planning meetings and offer comments. Meetings are held at the convenience of practitioners and service staff or provider agencies. Participation may be inconsistent and generally limited to planning activities. **3** ☐

- **Poor Role and Voice in Decisions.** The person may be notified late about the team meetings with few, if any, supports offered to facilitate participation. The person may be occasionally allowed to attend service planning meetings. Meetings may be held at the convenience of agency staff or provider agencies. Plans may be made before the meetings and the person may be expected to accept what is offered. **2** ☐

- **Not Participating/No Role and Voice in Decisions.** Service planning and decision-making activities may be conducted at times and places or in ways that prevent effective consumer participation. Decisions may be made without the knowledge or consent of the person. Services may be denied because of failure to show or comply. Appropriate and attractive alternative strategies, supports, and services may not be offered. Important information may be withheld. Procedural safeguards may be violated. **1** ☐

STATUS REVIEW 10: EDUCATION/CAREER DEVELOPMENT

EDUCATION/CAREER DEVELOPMENT: • Is this person actively engaged in educational activities (e.g., adult basic education, GED course work, or post-secondary education) vocational training programs, or transitional employment? • Is the person receiving information about work benefits, access to work supports, rights, responsibilities, and advocacy? • If not, does this person have access to such opportunities, subject to the person's needs and preferences?

Opportunities to improve one's skills, knowledge, and life potential are important for all adults. Education and training are ways that people use to promote life-long learning, enhance life opportunities, and advance career possibilities. Subject to ability, choice, and support, a person with mental illness should be able to access learning activities available within the community. Learning activities include adult basic education, GED classes, post-secondary education (via community college, university, online courses) and vocational training programs for career preparation or advancement. Under provisions of Section 504, Rehabilitation Act, 1973, persons with disabilities may request and receive special accommodations from educational institutions that enable them to participate in and benefit from educational opportunities. Educational advocacy by a case manager, social worker, or counselor may be necessary to secure opportunities and accommodations for an adult with mental illness who meets enrollment criteria and who chooses to advance his/her education or career skill status. The focus of this review is placed upon the person's participation in adult learning opportunities available within the community and/or treatment setting. Concerns in this review include whether the person: (1) is aware of learning opportunities; (2) is assisted in enrollment and securing accommodations (including GED club houses; tutoring services; access to computers; consumer education about benefits, losses, access, rights, responsibilities, advocacy, and mental health programs), if eligible and interested; and (3) is participating with any special supports or services that may be necessary for the person's success. This review is not applicable for persons who, by choice, are not currently participating in such activities. Consideration of the person's stage of change* would be useful in understanding a person's refusal of opportunities.

Determine from Informants, Plans, and Records

1. Is the person aware of the learning activities and opportunities currently available in his/her community and/or treatment setting?

2. Does the person meet enrollment requirements to participate in and benefit from learning activities in the community that are of interest to the person ?

3. Is the person currently accessing and participating in a community learning activity? If so, what advocacy, support, or special accommodations are being provided to this person?

4. Is the person receiving consumer education information and advice on the financial and social benefits gained from employment, possible losses of SSI or Medicaid benefits, rights and responsibilities related to employment, and information about sources of advocacy and assistance?

5 If given assistance or support, would this person be interested and willing to continue his/her education?

6. Does this person need educational advocacy to gain access to learning activities, with special accommodations as necessary for participation and success? If so, has educational advocacy been offered or provided to this person?

7. Does this person's life situation (e.g., parent of a newborn infant, hospitalized, or elderly) or current work schedule prevent the person from pursuing learning opportunities at this time?

8. Has this person been offered educational opportunities recently but declined participation? At what stage of change is this person now operating?

Facts Used in Rating Status

**STAGES OF CHANGE:*

Five stages of change are defined as:

- *Precomtemplation: no intention to change behavior; may be unaware of problems or opportunities.*
- *Contemplation: are aware of problems or opportunities; thinks about acting, upon it but has not made a commitment to take action.*
- *Preparation: combines intention with early behaviors; planning to take action within the next month.*
- *Action: activities are being undertaken to modify behavior and take advantage of opportunities with commitment of time and energy.*
- *Maintenance: person works to make and consolidates gains while acting to prevent relapse or loss; may enter this stage within six months of behavior change.*

Learning the person's stage of change may be helpful in understanding a person's refusal or readiness to pursue recovery activities.

STATUS REVIEW 10: EDUCATION/CAREER DEVELOPMENT

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Education/Career Development.** The person has high aspirations and goals to pursue learning activities in the community. The person is actively and successfully engaged in formal educational activities (e.g., adult basic education, tutorial assistance, GED course work, or post-secondary education/bachelor's degree) or vocational training. The person may have needed, requested, and received excellent educational advocacy (including financial assistance), support, and/or special accommodations to access and benefit from learning opportunities. The person may be making excellent progress. **6** ☐

- **Good Education/Career Development.** The person has many aspirations and goals to pursue learning activities in the community. The person is actively and substantially engaged in formal educational activities (e.g., adult basic education, GED course work, tutorial assistance, or post-secondary education) or vocational training. The person may have needed, requested, and received good educational advocacy (including financial assistance), support, and/or special accommodations to access and benefit from learning opportunities. The person may be making good progress. **5** ☐

- **Fair Education/Career Development.** The person has some aspirations and goals to pursue learning activities in the community. The person is somewhat engaged in formal educational activities (e.g., adult basic education, GED course work, or post-secondary education) or vocational training. The person may have needed, requested, and received some educational advocacy, support, and/or special accommodations to access and benefit from learning opportunities. The person may be making fair progress. **4** ☐

- **Marginal Education/Career Development.** The person has some aspirations and goals to pursue learning activities in the community. The person is marginally engaged in formal educational activities (e.g., adult basic education, GED course work, or post-secondary education) or vocational training. The person may have needed, requested, and received limited or inconsistent educational advocacy, support, and/or special accommodations to access and benefit from learning opportunities. The person may be making little progress. **3** ☐

- **Poor Education/Career Development.** The person has some aspirations and goals to pursue learning activities in the community. The person is poorly or inconsistently engaged in formal educational activities or vocational training. The person may have needed, requested, and received inadequate educational advocacy, support, and/or special accommodations necessary to access and benefit from learning opportunities. The person may be making poor or no progress. **2** ☐

- **Absent Education/Career Development.** The person has some aspirations and goals to pursue learning activities in the community. The person is not engaged in formal educational activities or vocational training. The person may have needed, requested, but received no educational advocacy, support, and/or special accommodations necessary to access and benefit from learning opportunities. The person is lacking the opportunity to make progress. **1** ☐

- **Not Applicable.** EITHER: The person is presently employed without need for further education or career preparation. OR: The person made an informed choice not to participate at this time. OR: The person may have a condition or situation that would prevent participation at this time (e.g., serious illness, incarceration, physical disability, traumatic brain injury, or advanced age -- frail elderly). **NA** ☐

STATUS REVIEW 11: WORK

WORK: • Is this person actively engaged in employment, competitive or supported (earning federal minimum wage or above, in an integrated community setting) or in an individual placement with supports in a productive situation? • If not, does the person doing productive opportunities in a consumer-operated services, an internationally accredited clubhouse, community center or library)?

Work gives meaning and value to one's life. Work provides a respected social role and a way to participate in and interact with others in the community. Work provides natural forms of affiliation and a way to develop friends via meaningful social contribution. Opportunities to offer one's skills, knowledge, and time for good purpose and personal benefit are important for adults. Subject to choice, a person with mental illness should be able to access and participate in productive activities available with in the community. Activities may include various forms of work (competitive, supported, full or part-time) job training -related activities that leads to employment. Under provision of Section 504, Rehabilitation Act, 1973 and the Americans with Disabilities Act (ADA), persons with disabilities may request and receive special accommodations from employers that enable them to participate in and benefit from employment opportunities. Advocacy and assistance by a case manager, social worker, employment support specialist/ job coach or counselor may be necessary to secure work or volunteer opportunities and accommodations for an adult with mental illness who seeks employment opportunities. Some individuals with a mental illness may require special supports to which they may be entitled through various government programs, such as Vocational Rehabilitation, Social Security Administration (Ticket to Work), or Temporary Assistance to Needy families (TANF).

The focus of this review is placed upon the person's participation in opportunities for work. Concerns here include whether the person is (1) is aware of productive opportunities and supports; (2) is assisted in all phases or choosing , getting and keeping employment as well as securing accommodations, if eligible and interested; and (3) is participating with any special supports or services that may be necessary for the persons success. This review is not applicable for a person, who by choice, is not currently participating in work. Yet, for these individuals a referral to a counselor/primary therapist should be initiated with in a few days to discuss the individual's fears, concerns or anxiety of not wanting to become engaged in employment. Consider the stage of change* at which the person is operating.

Determine from Informants, Plans, and Records

1. How is this person made aware of employment or work opportunities currently available in his/her community? Vocational rehabilitation, Work One Centers, Social Security Administration (Ticket to Work)?
2. How is the person currently accessing and participating in integrated, community based services and supports? How is advocacy, support(s) or special accommodations being provided to this person?
3. How was encouragement, engagement, assistance or support given to the individual in moving towards an attempt at trying/returning to work?
4. How was it determined that the individual needed assistance or advocacy to gain access to productive activities, (with special accommodations as necessary) for participation and success? If needed, how has advocacy been offered or provided to this person?
5. In what ways does the person's life situation or current educational schedule prevent the person from pursing productive opportunities at this time? What is being done to assist the individual? What choice of job, schedule, work site and supports has the person been offered?
6. How did the person receive options of his/her choice (s) or were options limited to jobs available in a particular program or service?
7. In what ways has educational information about the impact of earned income and gain of benefits been discussed with this person? Has assistance been offered to offset any benefits losses? Has the individual been counseled by a member of the Indiana Works team: a benefits planning assistance and outreach program reviewing Social Security benefits (1.866.646.8161 Northern Indiana and 1.800.825.4733 Southern Indiana) on the gains and risk of seeking and maintaining employment.

Facts Used in Rating Status

** STAGES OF CHANGE:*

Five stages of change are defined as:

- *Precomtemplation: no intention to change behavior; may be unaware of problems or opportunities.*
- *Contemplation: are aware of problems or opportunities; thinks about acting, upon it but has not made a commitment to take action.*
- *Preparation: combines intention with early behaviors; planning to take action within the next month.*
- *Action: activities are being undertaken to modify behavior and take advantage of opportunities with commitment of time and energy.*
- *Maintenance: person works to make and consolidates gains while acting to prevent relapse or loss; may enter this stage within six months of behavior change.*

Learning the person's stage of change may be helpful in understanding a person's refusal or readiness to pursue recovery activities.

STATUS REVIEW 11: WORK

Determine from Informants, Plans, and Records	Facts Used in Rating Status
8. Does the person have goals and plans for employment that are specific, measurable, attainable, results oriented and time framed that will assist in achieving their vocational ambitions and interest? 9. In what ways does the individual qualify for Indiana State Vocational Rehabilitation services ?(e.g. receives Social Security benefits, limited functioning in cognitive and learning skills, communication, interpersonal skills, mobility, motor skills, self care, self direction, work skill, work tolerance, or underemployed?	

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Work/Opportunities.** The person has aspirations and goals to pursue work in the community. And, the person is successfully engaged in activities (e.g., work or job training). The person may have needed, requested, and received excellent assistance, advocacy, support, and/or special accommodations to access and benefit from productive opportunities. The person may be experiencing excellent success in and significant benefits from current work or job training. **6** ☐

- **Good Work/Opportunities.** The person has aspirations and goals to pursue work in the community. And, the person is actively and substantially engaged in activities (e.g., work or job training). The person may have needed, requested, and received good levels of assistance, advocacy, support, and/or special accommodations to access and benefit from productive opportunities. The person may be experiencing good success and substantial benefits in his/her work or job training. **5** ☐

- **Fair Work/Opportunities.** The person has aspirations and goals to pursue work in the community. And, the person is frequently engaged in activities related to work or job training. The person may have needed, requested, and received minimally adequate levels of assistance, advocacy, support, and/or special accommodations to access and benefit from work related opportunities. The person may be experiencing a fair degree of success and some benefits in his/her work or job training. **4** ☐

- **Marginal Work/Opportunities.** The person has aspirations and goals to pursue work in the community. But, the person is seldom engaged in work or job training activities. The person may have needed, requested, and received limited or inconsistent assistance, advocacy, support, and/or special accommodations to access and benefit from productive opportunities. The person may be experiencing minor problems with and limited benefits in his/her productive activities. **3** ☐

- **Poor Work/Opportunities.** The person has aspirations and goals to pursue work in the community. But, the person is poorly or inconsistently engaged in productive activities. The person may have needed, requested, and received little or poor quality assistance, advocacy, support, and/or special accommodations to access and benefit from productive opportunities. The person may be experiencing significant problems with and few, if any, benefits in his/her productive activities. **2** ☐

- **Absent Work/Opportunities.** The person has aspirations and goals to pursue work in the community. But, the person is not engaged in productive activities. The person may have needed and requested, but not received assistance, advocacy, support, and/or special accommodations necessary to access and benefit from productive opportunities. The person is lacking the opportunity to be productive. **1** ☐

- **Not Applicable.** EITHER: The person made an informed choice not to participate at this time. OR: The person may be a fulltime homemaker caring for young children in the home and chooses not work at this time. OR: The person may have a condition or situation that would prevent participation at this time (e.g., seriously illness, incarceration, physical disability, traumatic brain injury, or advanced age — frail elderly). **NA** ☐

STATUS REVIEW 12: RECOVERY ACTIVITIES

RECOVERY ACTIVITIES: • To what degree is this person actively engaged in activities necessary to improve capabilities, competencies, coping, self-management, social integration, and recovery? • If not engaged in recovery, does this person have access to recovery and relapse prevention opportunities, subject to his/her needs, life ambitions, and personal preferences?

Recovery activities may involve use of various forms of medical care along with psychosocial adjustment and vocational training/retraining in an effort to maximize functioning, adjustment, and recovery for a person having serious and persistent mental illness. Recovery aims to prepare the person physically, mentally, socially, and vocationally for the fullest possible life, consistent with his/her abilities, ambitions, and choices. It is an individualized, dynamic, and purposeful process built around skills training and support modalities, as well as directed socialization complementing therapy and retraining. Recovery activities and services aim to help a person make the best use of his/her capacities within as normal as possible social context. For a person with a serious and persistent mental illness, rehabilitation usually aims to: (1) prevent relapse and rehospitalization by achieving successful community support and services, (2) improve the person's quality of life by assisting the person manage his/her life, and (3) achieve valued social roles in the community. Recovery efforts focus on strengthening the person's skills and developing the environmental supports necessary to sustain the person in the community. Successful recovery depends on a network of community services. The focus in this review is placed on access to and use of recovery and relapse prevention support opportunities. Recovery support activities are oriented toward successful community living and self-directed life management. This review may be deemed not applicable for a person who is functioning independently and successfully in the community or who declines recovery opportunities after reasonable, ongoing efforts to engage the person via outreach with attractive offers of supports and services. Consider the stage of change* at which the person is operating.

Determine from Informants, Plans, and Records

1. What outreach and engagement efforts are being used to develop this person's interests in recovery and relapse prevention opportunities?

2. Is this person currently participating in recovery activities? If not, why not?

3. What recovery/relapse prevention opportunities have been offered to this person? If the person declined participation, what efforts were made to engage the person? Were reasonable and attractive choices (to the person) offered? What supports or incentives were offered?

4. What is the nature of recovery activities in which the person is now participating: a general program for a group of participants or individually tailored services and activities designed to meet specific needs and personally selected goals?

5. Do recovery activities offered or used include skills development, social networking, hope, coping, self-agency, self-management, relapse prevention/ support, restarting recovery, and choices about where and how to work the process?

6. Given current recovery services, is the person making progress toward achievement of personally selected recovery goals? Does the person see them as meaningful?

7. Has this person progressed to the self-management and sustainability stage of recovery?

8. Are any of the available recovery activities peer operated?

Facts Used in Rating Status

** STAGES OF CHANGE:*

Five stages of change are defined as:

- *Precomtemplation: no intention to change behavior; may be unaware of problems or opportunities.*
- *Contemplation: are aware of problems or opportunities; thinks about acting, upon it but has not made a commitment to take action.*
- *Preparation: combines intention with early behaviors; planning to take action within the next month.*
- *Action: activities are being undertaken to modify behavior and take advantage of opportunities with commitment of time and energy.*
- *Maintenance: person works to make and consolidates gains while acting to prevent relapse or loss; may enter this stage within six months of behavior change.*

Learning the person's stage of change may be helpful in understanding a person's refusal or readiness to pursue recovery activities.

STATUS REVIEW 12: RECOVERY ACTIVITIES

Description and Rating of the Person's Current Status

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Recovery Activities.** The person has the need, ambition, and interest to pursue recovery opportunities. And, the person is highly motivated to participate in rehabilitative activities. The person may have been engaged via an excellent outreach effort and/or a change in his/her mental health status. The person may have needed, requested, and received excellent assistance, advocacy, and support to access and benefit from recovery opportunities. The person may be experiencing excellent progress toward accomplishing personally chosen life goals and recovery. **6** ☐

- **Good Recovery Activities.** The person has the need, ambition, and interest to pursue recovery opportunities. And, the person is substantially motivated to participate in rehabilitative activities. The person may have been engaged via a positive outreach effort. The person may have needed, requested, and received good assistance, advocacy, and support to access and benefit from recovery opportunities. The person may be experiencing good and substantial progress toward accomplishing personally chosen life goals and recovery. **5** ☐

- **Fair Recovery Activities.** The person has the need, ambition, and interest to pursue recovery opportunities. And, the person is somewhat motivated to participate in rehabilitative activities. The person may have been engaged via a modest outreach effort. The person may have needed, requested, and received minimally adequate assistance, advocacy, and support to access and benefit from recovery opportunities. The person may be experiencing fair progress toward accomplishing personally chosen life goals and recovery. **4** ☐

- **Marginal Recovery Activities.** The person has the need, ambition, and interest to pursue recovery opportunities. But, the person has difficulty in sustaining motivation to participate in rehabilitative activities. The person may have been engaged via a limited outreach effort. The person may have needed, requested, and received limited or inconsistent assistance, advocacy, and support to access and benefit from recovery opportunities. The person may be experiencing limited progress toward accomplishing goals possibly set by others. **3** ☐

- **Poor Recovery Activities.** The person has the need, ambition, and interest to pursue recovery opportunities. But, the person has not been able to sustain motivation to participate in rehabilitative activities. The person may not have been engaged via outreach efforts for a variety of current reasons or may have had a previous negative experience. The person may have needed, requested, and received inadequate assistance, advocacy, and support to access and benefit from recovery opportunities. The person may be experiencing little, if any, progress toward accomplishing goals. **2** ☐

- **Absent Recovery Activities.** The person has the need, ambition, and interest to pursue recovery opportunities. But, the person cannot agree to participate in rehabilitative activities. The person may not have been engaged via outreach efforts for a variety of long-standing reasons or may have had previous negative experiences. The person may have needed or requested, but not received any assistance, advocacy, and support to access and benefit from recovery opportunities. The person may be experiencing no progress toward life goals or could be becoming increasingly isolated or disabled. **1** ☐

- **Unable to Participate at this Time.** The person may have a condition or situation that would prevent participation at this time (e.g., terminal illness, incarceration, major physical disabilities, traumatic brain injury, or advanced age -- frail elderly). **NA** ☐

SECTION 3

PROGRESS INDICATORS

[PROGRESS OVER THE PAST 180 DAYS OR SINCE ADMISSION, IF LESS THAN 180 DAYS]

Progress Indicators

PROGRESS REVIEW 1: REDUCTION OF PSYCHIATRIC SYMPTOMS

SYMPTOM MANAGEMENT: To what extent are troublesome symptoms of mental illness being reduced, coped with, and personally managed by this individual?

A person receiving treatment for mental illness/addiction/substance use may have one or more diagnoses based on psychiatric symptoms and other conditions. As a result of treatment intervention (e.g., psychiatric medications) and recovery support, symptoms of disorders are expected to diminish over time. Effective treatment response is accompanied by reduction in symptoms and, hopefully, restoration of the person to adequate functioning. Persons receiving appropriate treatment are expected to experience reduction in symptoms over the course of treatment and recovery. Medications alone, however, are seldom sufficient to eliminate or prevent the recurrence of some troubling symptoms. For this reason, recovery efforts are aimed at helping the person develop coping strategies that promote the person's self-management and tolerance of those symptoms without accompanying losses in daily functioning.

The purpose of this review is to determine the person's progress in the reduction and self-management of bothersome symptoms associated with the disorder or condition being treated. The reviewer should use the scale provided below to report the degree of progress in symptom reduction reported by informants and records in this case.

Description and Rating of the Person's Recent Progress

Description of the Status Situation Observed for the Person	Rating Level
◆ **Optimal Progress.** The person is making excellent progress in symptom reduction, coping, and self-management at a level well above expectation. The disorder maybe in partial-to-full remission. There no longer may be any symptoms or signs of disorder or the person is coping exceptionally well with persisting symptoms of a troublesome nature. Functioning is now similar to previous favorable levels.	**6** ☐
◆ **Good Progress.** The person is making good and substantial progress in symptom reduction, coping, and self-management at a level somewhat above expectation. Coping and self-management are at a good and consistent level. Symptoms do not interfere with the person's life and pursuit of happiness.	**5** ☐
◆ **Fair Progress.** The illness is now at a mild-to-moderate level with some symptoms or functional impairments still present in social or work settings. Coping and self-management are at a fair level. Symptoms may sometimes minimally interfere with the person's life and pursuit of happiness.	**4** ☐
◆ **Marginal Progress.** The person is making limited or inconsistent progress in symptom reduction, coping, and self-management at a level that is uncomfortable and that reduces or impairs some life functions. Coping and self-management are at a limited or inconsistent level. The illness is now at a moderate level with substantial symptoms or functional impairments present in social or work settings.	**3** ☐
◆ **No Progress.** The illness is now at a moderate-to-severe level with many symptoms and marked functional impairments present in social or work settings. Coping and self-management remain at an impaired level. Risks of restriction, isolation, increased disability, or injury may be present.	**2** ☐
◆ **Decline.** The person's symptoms are increasing. Serious symptoms and increasing functional limitations may be present across settings. Overwhelming symptoms are out-running the person's coping capacity and self-management capabilities at the present time. Risks of increased restriction, isolation, disability, or injury are high.	**1** ☐
◆ **Not Applicable or Not Indicated. EITHER**: The person was functioning at a good to optimal level at the beginning of the observation period (6 months ago, or since admission -- if less that 6 months) and has maintained that level over the course of this time period. **OR:** There were/are compelling medical reasons to defer change in this area over the observation period (e.g, hospitalization for a serious physical illness or pregnancy).	**NA** ☐

PROGRESS REVIEW 2: REDUCTION OF SUBSTANCE ABUSE IMPAIRMENT

REDUCTION OF SUBSTANCE ABUSE: To what extent is the person making progress in reducing substance use and related impairments, while achieving sobriety, relapse prevention, and improved self-management of life choices that promote recovery?

Substance use activities, related impairments, and their adverse social consequences may cause significant difficulties for functioning in daily settings and activities. Overcoming addiction and/or substance use impairment and building appropriate functional behavior patterns while reducing behaviors that may cause problems in social and work settings may be addressed through residential treatment, medications, relapse prevention strategies, positive behavioral supports, rehabilitative services, and lifestyle changes developed uniquely for and with the person or through a combination of these modalities. Where appropriate, the person's recovery should be evaluated on the basis of the person's improvement over time. The person either should be presenting improved functional behavior patterns in daily settings or should be demonstrating substantial progress toward sobriety, relapse prevention, improved functioning, problem solving, and self-management of recovery. Persons with substance use impairment may require specialized or intensive supports and services for a period of time to participate in community settings, consistent with the person's preferences. The person should be learning how to understand and meet daily life challenges encountered at home, at work, and in the community as a part of recovery and increasing self-management. This may include a step-by-step process of meeting short-term goals that increases hope for recovery and demonstrates practical progress in self-management. The reviewer should rate the person's progress in achieving sobriety and using social and self-management skills in community settings, according to the person's culture, ambitions, and present opportunities for improvement.

Description and Rating of the Person's Recent Progress

Description of the Status Situation Observed for the Person	Rating Level
◆ **Optimal Progress.** The person is making excellent progress toward sobriety, relapse prevention, coping, and self-management at a level well above expectation. The substance use impairment maybe in partial-to-full remission. There no longer may be any symptoms or signs of disorder or the person is coping exceptionally well with persisting symptoms of a troublesome nature. Functioning is now similar to previous favorable levels.	**6** ☐
◆ **Good Progress.** The person is making good and substantial progress toward sobriety, relapse prevention, coping, and self-management at a level somewhat above expectation. Coping and self-management are at a good and consistent level. Symptoms do not interfere with the person's life and pursuit of happiness.	**5** ☐
◆ **Fair Progress.** The illness is now at a mild-to-moderate level with only minor, infrequent use or functional impairments still present in social or work settings. Progress toward sobriety, relapse prevention, coping and self-management are at a fair level. Substance use may sometimes minimally interfere with the person's life.	**4** ☐
◆ **Marginal Progress.** The person is making limited or inconsistent progress toward sobriety, relapse prevention, coping, and self-management at a level that is uncomfortable and that reduces or impairs some life functions. Sobriety, coping and self-management are at a limited or inconsistent level. Substance use may be at a moderate level with substantial functional impairments present in social or work settings.	**3** ☐
◆ **No Progress.** The addiction or substance use pattern is now at a moderate-to-severe level with many marked functional impairments present in social or work settings. Life choices, coping and self-management remain at an impaired level. Risks of arrest, restriction, isolation, increased disability, or injury may be present.	**2** ☐
◆ **Decline.** The person's addiction impairments are increasing. Serious substance use and increasing functional limitations may be present across settings. Overwhelming addiction effects are out-running the person's coping capacity and self-management capabilities at the present time. Risks of increased harm are high.	**1** ☐
◆ **Not Applicable or Not Indicated. EITHER**: The person was functioning at a good to optimal level at the beginning of the observation period (6 months ago, or since admission -- if less that 6 months) and has maintained that level over the course of this time period. **OR:** There were/are compelling medical or legal reasons to defer change in this area over the observation period.	**NA** ☐

PROGRESS REVIEW 3: IMPROVED PERSONAL RESPONSIBILITIES

IMPROVED PERSONAL RESPONSIBILITIES: To what extent is the person making progress in key life areas, including relapse prevention and self-management in the community, where appropriate?

Individuals with serious mental illness and/or substance use impairments may encounter more difficulties functioning in daily settings and activities than other persons. Building appropriate functional behavior patterns, changing lifestyle choices and reducing behaviors that may cause problems in social and work settings may be addressed through in-patient treatment, positive behavioral supports, rehabilitative services developed uniquely for and with the person, use of medications, or a combination of these modalities. Where appropriate, the person's recovery efforts should be evaluated on the basis of his/her improvements in personal responsibilities over time. The person either should be presenting functional behavior patterns in daily settings or should be demonstrating substantial progress toward improved functioning, problem solving, relapse prevention, and self-management. Persons with mental illness or addiction may require specialized or intensive supports and services for a period of time to participate in community settings, consistent with the person's preferences. The person should be learning how to understand and meet daily life challenges encountered at home, at work, and in the community as a part of recovery and increasing self-management. This may include a step-by-step process of meeting short-term goals that increases hope for recovery and demonstrates practical progress in self-management. The reviewer should rate the person's progress in acquiring and using social and self-management skills in community settings, according to the person's culture, ambitions, and opportunities for improvement.

Description and Rating of the Person's Recent Progress

Description of the Status Situation Observed for the Person	Rating Level
◆ **Optimal Improvement.** The person is performing above expectation, based on the person's hopes, goals, and short-term steps, in settings in which he/she lives, works, and plays. He/she takes full responsibility for his/her life and asks for assistance when needed. There is evidence of excellent progress in recovery efforts related to better community functioning and independent self-management.	**6** ☐
◆ **Good Improvement.** The person is performing at expectation, based on the person's hopes, goals, and short-term steps, in settings in which he/she lives, works, and plays. He/she takes some responsibility consistently for his/her life and occasionally asks for assistance when needed. There is evidence of good progress in recovery efforts related to better community functioning and independent self-management.	**5** ☐
◆ **Fair Improvement.** The person is performing near expectation, based on the person's hopes, goals, and short-term steps, in daily settings. He/she takes some responsibility intermittently for his/her life and still relies on staff for assistance in many aspects of his/her life. There is evidence of minimally adequate to fair progress in recovery related to community functioning and independent self-management.	**4** ☐
◆ **Marginal Improvement.** The person is performing below expectation, based on the person's hopes, goals, and short-term steps, in settings in which he/she lives, works, and plays. He/she rarely or intermittently takes responsibility for his/her life and has not reduced reliance on staff assistance. There is evidence of limited or inconsistent progress in recovery efforts related to community functioning and independent self-management.	**3** ☐
◆ **Poor Improvement.** The person is performing far below expectation, based on the person's hopes, goals, and short-term steps, in settings in which he/she lives, works, and plays. He/she continues to use staff assistance to a large degree for task support and decisions. There is little, if any, evidence of progress in recovery efforts related to community functioning and independent self-management.	**2** ☐
◆ **No Improvement or Decline.** The person is not improving or may be declining in daily functioning in the settings where he/she lives, works, and plays, based on reports from informants, progress notes, and other evidence.	**1** ☐
◆ **Not Applicable.** The person was functioning at a good to optimal level at the beginning of the observation period (6 months ago, or since admission -- if less that 6 months) and has maintained that level over the course of this time period. **OR:** There were/are compelling medical or legal reasons to defer change in this area over the observation period.	**NA** ☐

PROGRESS REVIEW 4: EDUCATION/WORK PROGRESS

EDUCATION/WORK PROGRESS: To what extent is this person presently making progress toward educational course completion - OR - making progress toward getting and keeping a job?

Consistent with the person's ambitions and choices, the person may be actively engaged in educational, vocational, or employment processes that are enabling the person to build skills and functional capabilities necessary for a productive life in the community. The person may be participating in educational activities (e.g., adult basic education, GED course work, or post-secondary education), vocational training programs, and/or employment (competitive, supported, transitional; either paid or voluntary). The expectation is that the person, consistent with his/her personal ambitions and preferences, is making goal-related progress while making use of any supports that may be required for the person's participation and success. If the person has completed or dropped out of school and is working, then progress in satisfying expectations of the employer and making career advancement is the focus of rating progress in this review.

Description and Rating of the Person's Recent Progress

Description of the Status Situation Observed for the Person	Rating Level
◆ **Optimal Education/Work Progress.** The person is working **above expectation,** based on the person's hopes, goals, and short-term steps, in his/her educational classes, vocational program, or job situation.	6 ☐
◆ **Good Education/Work Progress.** The person is working **at expectation,** based on the person's hopes, goals, and short-term steps, in his/her educational classes, vocational program, or job situation.	5 ☐
◆ **Fair Education/Work Progress.** The person is working **near expectation,** based on the person's hopes, goals, and short-term steps, in his/her educational classes, vocational program, or job situation.	4 ☐
◆ **Marginal Education/Work Progress.** The person is working **below expectation,** based on the person's hopes, goals, and short-term steps, in his/her educational classes, vocational program, or job situation.	3 ☐
◆ **Poor Education/Work Progress.** The person is working **well below expectation,** based on the person's hopes, goals, and short-term steps, in his/her educational classes, vocational program, or job situation.	2 ☐
◆ **No Education/Work Progress.** The person is **showing no progress or no longer works** in his/her educational classes, vocational program, or job situation.	1 ☐
◆ **Not Applicable.** EITHER: The person made an informed choice not to participate at this time. OR: The person may be a fulltime homemaker caring for young children in the home and chooses not work at this time. OR: The person may have a condition or situation that would prevent participation at this time (e.g., seriously illness, incarceration, physical disability, traumatic brain injury, or advanced age — frail elderly). OR**:** There were/are compelling life-stage, medical, or legal reasons to defer change in this area over the observation period.	NA ☐

PROGRESS REVIEW 5: PROGRESS TOWARD RECOVERY GOALS

PROGRESS TOWARD PERSONAL RECOVERY GOALS: To what degree is the person making progress toward attainment of personally selected recovery goals that may be stated in his/her recovery plan?

To achieve and maintain good health, reduce psychiatric symptoms, attain sobriety, and/or to make recovery progress in key life areas (e.g., communications, self-care, mobility in the community, coping, self-management, social connection/affiliation, capacity for independent living, employment), a person with mental illness or substance use impairment may choose *[subject to medical necessity]* clinical services (e.g., nursing, physical therapy, speech therapy, occupational therapy, psychiatric services), psycho-social rehabilitative services, education or training, and/or supportive services to improve his/her life situation. Such services may be necessary in order for a person to participate in and benefit from other life opportunities, such as education, work, or social integration in the community. Recovery-related services should be supportive of the person's self-selected life goals expressed in his/her recovery plans. Depending on the person's needs, support may be required to master a broad range of potential goals, from basic functional behaviors (e.g., mobility following an injury) to sophisticated social behaviors (e.g., respectful social interactions in group situations) to self-management of troublesome symptoms. Recovery goals should define competencies to be achieved with clinical, psychosocial, or supportive services targeting skill acquisition, social network development, and life management. Progress may be assessed via a variety of procedures including, but not limited to, observation, functional data collection, self-report, and formal or informal assessments. The focus in this review is on the person's progress made toward the achievement of personally selected goals that may be expressed in his/her recovery plans. The expectation is that the person is or should be receiving treatment/support related to those goals. If the person does not wish to pursue recovery goals at the present time, this review is not applicable.

Description and Rating of the Person's Recent Progress

Description of the Status Situation Observed for the Person — Rating Level

- **Optimal Recovery Progress.** The person wishes to achieve life goals in areas that may require clinical services and/or psychosocial supports and is willing to actively participate in those services at this time. The person is progressing above expectation based on the person's hopes, goals, and short-term steps in achieving recovery goals. The person is making excellent progress in all goal areas. — **6** ☐

- **Good Recovery Progress.** The person wishes to achieve life goals in areas that may require clinical services and/or psychosocial supports and is willing to actively participate in those services at this time. The person is at expectation, based on the person's hopes, goals, and short-term steps, in achieving recovery goals. The person is making good and continuing progress in most goal areas. — **5** ☐

- **Fair Recovery Progress.** The person wishes to achieve life goals in areas that may require clinical services and/or psychosocial supports and is willing to actively participate in those services at this time. The person is near expectation, based on the person's hopes, goals, and short-term steps, in achieving recovery goals. The person is making minimally adequate to fair progress in at least some goal areas. — **4** ☐

- **Marginal Recovery Progress.** The person wishes to achieve life goals in areas that may require clinical services and/or psychosocial supports and is somewhat willing to actively participate in those services at this time. The person is somewhat below expectation, based on the person's hopes, goals, and short-term steps, in achieving recovery goals. The person is making limited or inconsistent progress in some goal areas. — **3** ☐

- **Poor Recovery Progress.** The person wishes to achieve life goals in areas that may require clinical services and/or psychosocial supports and is somewhat willing to actively participate in those services at this time. The person is far below expectation, based on the person's hopes, goals, and short-term steps, in achieving recovery goals. The person is making slight or erratic progress in at least a few goal areas. — **2** ☐

- **No Progress or Decline.** The person wishes to achieve life goals in areas that may require clinical services and/or psychosocial supports and is inconsistently willing and/or able to actively participate in those services at this time. The person is not progressing or may be declining in some or many recovery goal areas. — **1** ☐

- **Not Applicable.** The person was functioning at a good to optimal level at the beginning of the observation period (6 months ago, or since admission -- if less that 6 months) and has maintained that level over the course of this time period. **OR:** There were/are compelling life-stage, medical or legal reasons to defer change in this area over the observation period. — **NA** ☐

PROGRESS REVIEW 6: RISK REDUCTION

RISK REDUCTION: To what extent is reduction of risks of harm, self-endangerment, use of chemical substances, and/or utilization of coercive techniques being accomplished with and for this person?

Due to a combination of life circumstances and/or functional limitations, some persons with mental illness or substance use impairment may be at risk of physical harm, arrest, poor recovery outcomes, or high utilization of restrictive services and coercive techniques. If the person is at elevated risk of harm (e.g., health crisis, physical abuse, substance use, or self-injury) or at elevated risk of an undesirable outcome (e.g., disease, addiction, arrest, acute inpatient hospitalization, homelessness), then such risks and their reduction should be addressed in the treatment and recovery process. Identification of risks for a person should include case history of past harmful events, present risk factors, life stressors, and service utilization patterns. Due diligence in practice requires that clinicians, case managers, and support providers spot and respond to serious risks. Recognized risks (e.g., serious physical abuse via domestic violence in the home) should be reduced and potentially harmful events (e.g., self-injurious behavior) should be prevented or managed over time via interventions and supports. History is the best predictor of risk and persons should be involved in describing their risks and managing them. Not all persons with mental illness or substance use impairments present such risks. In a case where diligent assessment is made and no risks are identified, this review is deemed not applicable.

Description and Rating of the Person's Recent Progress

Description of the Status Situation Observed for the Person	Rating Level
◆ **Optimal Risk Reduction.** Excellent ongoing identification and mitigation of risks have occurred over the past six months. Known risks have been very well managed, risk patterns have declined significantly, and likelihood of harm or poor outcomes is being prevented or signifiantly reduced.	**6** ☐
◆ **Good Risk Reduction.** Good and consistent identification and mitigation of risks have occurred over the past six months. Known risks have been generally well managed, risk patterns have declined substantially, and likelihood of harm or poor outcomes is being substantially reduced.	**5** ☐
◆ **Fair Risk Reduction.** Minimally adequate to fair identification and mitigation of risks have occurred over the past six months. Known risks have been at least minimally managed, risk patterns have declined somewhat, and likelihood of harm or poor outcomes is being somewhat reduced.	**4** ☐
◆ **Marginal Risk Reduction.** Identification of risks may be spotty, shallow, or inconsistent, leading to a confusing picture. Known risks have been marginally managed, risk patterns have declined to a limited or inconsistent degree, and likelihood of harm or poor outcomes is present but at a somewhat lowered level of probability.	**3** ☐
◆ **Poor Risk Reduction.** Identification of risk is poor, e.g., incomplete, conflictual, or questionable. Responses to identified or suspected risks may be delayed, misdirected, ineffective, or uncoordinated. Risks may be misunderstood or undetected. Risks have not been reduced to any consequential degree. The likelihood of harm or poor outcomes may be present at a moderate-to-high level of probability.	**2** ☐
◆ **Adverse Risk Reduction.** Identification of risk is erroneous, is obsolete, or may be entirely missing. Responses to identified or suspected risks may be missing, contrary to good practice, ineffective, adverse in effect, or not performed when needed. Risks have not been reduced over the past six months. Risks of harm to the person may be high and increasing.	**1** ☐
◆ **Not Applicable.** No evidence of risk is revealed after a diligent assessment by treatment staff and an appropriate review of the person and his/her circumstances. This review is deemed not applicable to the person at this time.	**NA** ☐

PROGRESS REVIEW 7: SUCCESSFUL LIFE ADJUSTMENTS

SUCCESSFUL LIFE ADJUSTMENTS: Consistent with this person's needs and goals, to what extent is the person making successful transitions and life adjustments between living settings, service providers, levels of care, and from dependency to personal control and direction?

Transitions and life adjustments are a part of the normal human experience. For most people, transitions and life adjustments are important and sometimes challenging, but such changes may be especially difficult for a person with mental illness or substance use impairment. This is because new learning, special arrangements, accommodations, supports, or services may be necessary to accomplish a smooth and successful transition from one setting, program level, service provider, and set of relationships to another. Many different kinds of transitions and adjustments may play out in a person's life. Some may involve personal losses or changing life stages that are natural and unavoidable aspects of life. For a person with mental illness, more immediate transitions and adjustments may involve changes in living settings, service providers, levels of care, and natural progression from dependency to personal control and direction of one's life. For a person requiring support or assistance, transitions may require diligent identification and planning of special transition goals, preparation for/staging of events to maintain stability during the change process, and provision of related recovery supports during and following change to promote functional life adjustments. Progress is assessed in the context of the person's support requirements and the timely provision of necessary supports and services in advance of the transition, during the transition, and for a 30-day period following the transition to assess adjustment success. In a case where diligent identification assessments are made but no transition-related needs and life adjustments are identified within the observation period, this progress indicator is then deemed not applicable at this time.

Description and Rating of the Person's Recent Progress

Description of the Status Situation Observed for the Person	Rating Level
◆ **Optimal Life Adjustments.** The person is making optimal progress toward achievement of an excellent and successful transition and life adjustment according to an appropriate sequencing of related events (i.e., advance planning, making near-term arrangements, facilitating transition activities, following along in the new setting, and following up for a 30-day adjustment period, as appropriate to the transition situation).	**6** ☐
◆ **Good Life Adjustments.** The person is making good progress toward achievement of a smooth and successful transition and life adjustment according to an appropriate sequencing of related events and support activities. No significant problems have been encountered.	**5** ☐
◆ **Fair Life Adjustments.** The person is making minimally adequate progress toward achievement of a fair transition and life adjustment according to a minimally adequate sequencing of related events and support activities. A few minor difficulties might be encountered but are being or have been resolved.	**4** ☐
◆ **Marginal Life Adjustments.** The person is making limited and inconsistent progress toward achievement of transition and life adjustment according to a marginal sequencing of related events and support activities. Delays or difficulties might be encountered that are limiting transition supports and progress.	**3** ☐
◆ **Poor Life Adjustments.** The person is making poor and inadequate progress toward a difficult transition and life adjustment according to inadequate sequencing of related events and support activities. Inadequate transition planning or breakdowns are present that are hindering transition efforts.	**2** ☐
◆ **Adverse Life Adjustments.** The person should be in a structured and coordinated transition process but is not being supported and/or is encountering foreseeable and preventable difficulties. The person is experiencing unnecessary hardship, adjustment difficulties, or loss of prospective opportunities due to unacceptable transition planning and consequential life adjustment difficulties.	**1** ☐
◆ **Not Applicable.** Identification efforts reveal no evidence of needs to be addressed via transition and life adjustment, supports, or services for this person at this time. This indicator is deemed not applicable.	**NA** ☐

PROGRESS REVIEW 8: IMPROVEMENT IN SOCIAL INTEGRATION

IMPROVEMENT IN SOCIAL INTEGRATION: • To what degree is this person increasing his/her social connections among a variety of social groups in the community, consistent with the person's recovery goals? • Does the person access services and participate in social group activities available to all citizens? • Does this person affiliate with community groups (secular or sacred), with special accommodations and supports, consistent with the person's desires? • Is the person benefiting from increased social integration in the community?

As a person with mental illness or substance use impairments progressively recovers from serious psychiatric symptoms/substance abuse and social impairments to reach higher levels of functioning, a major thrust of recovery becomes the social integration of the person into his/her community. Restoring the person to the community becomes a major focus of recovery. Such a person should have access to the same community services and activities as do other citizens of the community. The person should have the opportunity, freedom, and support to determine the degree of contact he/she wants to have with social groups in the community. And, the person should be able to decide his/her degree of participation in community life, based on his/her interests and preferences. As interests change, the person may choose to increase the range and frequency of contacts and activities in community life. Benefits of social integration include belonging to social groups, performing social roles, interacting with other members of the community, and enjoying community activities and events that add meaning and interest to life. The focus of this review is on recent progress made by the person in improving his/her degree of social integration. This review may not apply to a person who is behaving in ways that are not socially acceptable, who may be in a restrictive setting, or who may choose to remain isolated from others in the community even after diligent efforts have been made to engage the person by repeatedly offering him/her a variety of attractive social integration opportunities.

Description and Rating of the Person's Recent Progress

Description of the Status Situation Observed for the Person	Rating Level
◆ **Optimal Social Integration.** The person has had access to and/or participated to a high degree in a wide variety of available social group opportunities consistent for his/her situation and interests (with accommodations and supports, as needed). He/she has significantly increased social connections with demonstrated optimal improvement (consistent with recovery goals) and has experienced significant social benefit.	**6** ☐
◆ **Good Social Integration.** The person has had access to and/or participated to a substantial degree in several available social integration opportunities appropriate for his/her situation and interests (with accommodations and supports, as needed) and has demonstrated substantially increased social integration with good social benefits from such participation. Participation and benefits are likely to continue if present supports remain.	**5** ☐
◆ **Fair Social Integration.** The person has had access to and/or participated to a fair degree in at least one available social integration appropriate for his/her situation and interests (with accommodations and supports, as needed) and has demonstrated minimally adequate to fair improvement in social connections and some social benefits from such participation. Participation and benefits may be linked to certain persons and supports that may be somewhat limited in time availability or consistency.	**4** ☐
◆ **Marginal Social Integration.** The person occasionally has had access to and/or participated to a limited degree in at least one social integration opportunity showing limited or inconsistent improvement or limited social benefits from such participation. Social integration activities may be limited in number or scope. Special accommodations and supports may be substantially limited in availability, consistency, or effectiveness.	**3** ☐
◆ **Poor Social Integration.** The person has had access to and/or participated inconsistently in social integration opportunities for his/her situation and interests with generally poor results and questionable social benefits from such participation. Social integration activities may be limited in number or scope. Special accommodations and supports may be severely limited in availability, consistency, or effectiveness.	**2** ☐
◆ **Adverse Social Integration.** The person has not had access to and/or has not participated in social integration opportunities or may be adversely affected by participation.	**1** ☐
◆ **Not Applicable.** The person is unable or unwilling to participate in social integration opportunities at the present time. The person may be hospitalized, incarcerated, or otherwise unable to increase socialization.	**NA** ☐

PROGRESS REVIEW 9: IMPROVED MEANINGFUL PERSONAL RELATIONSHIPS

IMPROVED MEANINGFUL PERSONAL RELATIONSHIPS: • To what degree is the person improving meaningful personal relationships with peers, friends, and family members, consistent with the person's preferences?

As a person with mental illness/substance abuse progressively recovers from serious psychiatric symptoms, substance use patterns, and social impairments to reach higher levels of functioning, a major thrust of recovery becomes the connection or reconnection of the person to a circle of supporters consisting of friends, peers, and family members. The person should have the opportunity, freedom, and support to determine the degree of contact he/she wants to have with peers, friends, and family members. As interests change, the person may choose to increase the circle of support and frequency of contacts and activities with persons involved in his/her life. The focus of this review is on recent progress made by the person in improving his/her degree of connection with individuals who together form a circle of supporters. This review may not apply to a person who presently is presenting serious psychiatric symptoms, substance use, and impairments in functioning, who may be in a restrictive setting, or who may choose to remain isolated from others in the community even after diligent efforts have been made to engage the person by repeatedly offering him/her a variety of attractive social connection/reconnection opportunities.

Description and Rating of the Person's Recent Progress

Description of the Status Situation Observed for the Person	Rating Level
◆ **Optimal Progress in Building Relationships.** The person has been aggressively developing or restoring meaningful personal relationships and extending his/her circle of supporters (with accommodations and supports, as needed). He/she is demonstrating excellent improvement in and benefits from these personal relationships.	**6** ☐
◆ **Good Progress in Building Relationships.** The person has been consistently developing or restoring meaningful personal relationships and extending his/her circle of supporters (with accommodations and supports, as needed). He/she has demonstrated substantial improvement in and good benefits from these personal relationships.	**5** ☐
◆ **Fair Progress in Building Relationships.** The person is minimally developing or restoring meaningful personal relationships and extending his/her circle of supporters (with accommodations and supports, as needed). He/she has demonstrated minimal-to-fair improvement in and some benefits from these personal relationships.	**4** ☐
◆ **Marginal Progress in Building Relationships.** The person is marginally developing or restoring meaningful personal relationships and extending his/her circle of supporters (with some accommodations and supports). He/she is demonstrating limited or inconsistent improvement in and occasional benefits from these personal relationships.	**3** ☐
◆ **Poor Progress in Building Relationships.** The person is poorly developing or restoring meaningful personal relationships and extending his/her circle of supporters (with possibly limited accommodations and supports). He/she has demonstrated slight or erratic improvement in and few benefits from any social connections.	**2** ☐
◆ **No Progress in Building Relationships.** The person is not developing or restoring meaningful personal relationships nor extending his/her circle of supporters (with possibly little or no accommodations and supports). He/she has not demonstrated improvement in or any benefit from any social connections.	**1** ☐
◆ **Not Applicable.** The person is unable or unwilling to participate in relationship building or restoration over the past 6 months. The person may have been hospitalized, incarcerated, or otherwise unable to increase socialization.	**NA** ☐

SECTION 4

PRACTICE PERFORMANCE INDICATORS

[PERFORMANCE OBSERVED OVER THE PAST 90 DAYS]

PRACTICE REVIEW 1: ENGAGEMENT OF THE PERSON

ENGAGEMENT: • How well are interveners developing and maintaining a mutually beneficial partnership with the person that is sustaining his/her interest in and commitment to an intervention-driven recovery process? • To what extent have interveners taken action to form a trust-based working relationship with the person that is supporting practice functions necessary for recovery? • Are interveners open, receptive, and willing to make accommodations to increase the person's engagement and level of participation in recovery planning and work?

In addition to providing treatment interventions to support recovery, effective human services are based on relationships formed between persons in need and others who help them meet those needs. Success in the provision of services often depends on the quality and durability of relationships between those receiving services and those providing the services. This means that active efforts must be undertaken by those involved in the provision of services to reach out to the service consumer, to engage him/her meaningfully in all aspects of the recovery process, to build and maintain rapport and trusting relationships that endure through the course of actions taken, and then to thoughtfully conclude when circumstances require change or the recovery goals are achieved. Engagement strategies are intended to build a mutually beneficial partnership with the person and his/her supporters that builds and sustains their interest in and commitment to an active treatment and recovery process until recovery goals are achieved and sustainable supports are in place.

Engagement strategies used will vary according to the person's situation, will reflect his/her language and cultural background, and, in some situations, will balance recovery-focused practice principles with court-ordered requirements and constraints. Best practice teaches that providers should: (1) Approach the person from a position of respect and cooperation. (2) Engage the person around concerns for his/her health, safety, education/employment, social supports, and recovery. (3) Focus on the person's strengths (e.g., culture, traditions, values, skills, motivation for a better life) as building blocks for recovery, with his/her immediate needs as the catalyst for service delivery. (4) Help the person achieve a clear understanding of the opportunities and benefits of recovery. (5) Help the person define what he/she can do for him/herself and where others might provide treatment or support. (6) Engage the person in decision making about the choice of interventions and the reasons why a particular intervention might be effective. It may be necessary for the team to change the meeting time, location, participation, and process to help a person participate. The central focus of this review is placed on the diligence shown by the team in taking actions necessary to engage and build rapport with the person to overcome barriers to his/her participation. Emphasis is placed on direct, ongoing involvement in core service functions: assessment, lifestyle choices, recovery planning and decisions about who the providers will be, monitoring, modifications, and evaluation. Allowance should be made when services are imposed by court order for the person rather than being voluntary.

Determine from Informants, Plans, and Records

1. What outreach and engagement strategies are service providers using to build a working partnership with this person and his/her informal supporters? Are special accommodations made as necessary to encourage and support participation and partnership?

2. How well engaged is the person in the service process at this time? What engagement strategies work with this person? What does the person say?

3. Does the person demonstrate enthusiasm about interactions with service providers? Does he/she report being treated with dignity and respect? Does he/she have a trust-based working relationship with those providing services?

4. How is the person involved in the ongoing assessment of hi/her strengths, needs, circumstances, and progress? Do the person routinely participate in the monitoring/modification of the service arrangements?

5. Is the planning and implementation process person-centered and responsive to the person's particular cultural values? Do the person routinely participate in evaluation of the progress of the service process supporting recovery goals?

Facts Used in Rating Performance

NOTE:

Status Review 9: Voice & Role in Decisions and Caregiver Status Review 2: Satisfaction with Services may provide useful information to consider when rating Practice Review 1: Engagement of the Person. Remember that engagement focuses on the practice activities that lead to and support an active and effective partnership with the person and his/her family or informal supporters. When these engagement activities are effective, participation and satisfaction should be positive.

PRACTICE REVIEW 1: ENGAGEMENT OF THE PERSON

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Engagement Efforts**. Those involved in the service process, including the person and his/her invited supporters, report that they are full, effective, and ongoing partners in all aspects of assessment, planning services, making service arrangements, selecting providers, monitoring, and evaluating services and results. The person fully participates in planning personal recovery goals, deciding on service arrangements, and shaping the service process to support and achieve recovery. **- OR -** Excellent outreach efforts are used as necessary to engage a difficult to reach consumer, including scheduling time and location based on the person's convenience, support with transportation and child care, individualized problem solving, and time spent in whatever setting necessary to build the necessary relationship and rapport. Engagement efforts are made consistently and persistently over time. **6** ☐

- **Good Engagement Efforts**. Those involved in the service process, including the person and his/her invited supporters, report that the team has a strong, respectful partnership with the person and that they actively work to make arrangements so that the person can be a full participant. Providers and supports report that the person is well engaged and a satisfied member of the team. **- OR -** The team can identify many steps, strategies, and efforts that have been used to increase the person's engagement and involvement that have been made overtime. **5** ☐

- **Fair Engagement Efforts**. Those involved report and service records show that the person and some invited supporters are sometimes involved as partners in basic aspects of assessment, planning services, making service arrangements, monitoring, and evaluating services and results. The person sometimes assists in planning goals, deciding on service arrangements, and shaping the service process to support and achieve recovery. The person basically supports the service processes unfolding for him/her. **- OR -** Some outreach efforts are used as necessary to engage difficult-to-reach consumers and that the record shows a goal for engagement and repeated efforts by the team to constructively engage the person and his/her invited supporters. **4** ☐

- **Marginal Engagement Efforts**. Some persons involved report that the person and few, if any, invited supporters occasionally participate to a limited or inconsistent degree in service planning and occassional evaluation activities. The person may be allowed to participate in planning goals, deciding on service arrangements, and shaping the service process. The person and his/her invited supports may report having a somewhat uncertain or possibly strained relationship with service providers. **- OR -** The person has not been interested either because of dissatisfaction with the system or other reasons. Limited or inadequate outreach efforts have been made in sporadic efforts to engage the difficult-to-reach consumer. The team members do not know why the person will not engage in the process or have made assumptions that may not be accurate of the actual situation. **3** ☐

- **Poor Engagement Efforts**. Some persons involved report that neither the person or any of the person's informal supporter ever participate even to a limited degree in service planning and annual evaluation activities. The person may report having a poor or possibly conflicted relationship with service providers. **- OR -** No efforts have been made by the team to increase the person's engagement and participation, though a team member may report that having made some effort to establish rapport with at least some of the person's family or informal supporters. **2** ☐

- **No Engagement Efforts**. Service planning and decision-making activities are conducted at times and places or in ways that prevent or severely limit effective involvement and participation by the person. Decisions are made without the knowledge or consent of the person or person's guardian, if appropriate. Services may be denied because of failure to show or comply. Appropriate and attractive alternative strategies, supports, and services are not offered. Important information may not be provided to the person, guardian or informal supporters. Procedural or legal safeguards may be violated. **1** ☐

PRACTICE REVIEW 2: TEAMWORK

• TEAM FORMATION: To what degree: (1) Have the "right people" for this person formed a working team that meets, talks, and plans together? (2) Does the team have the skills, knowledge of this person, and abilities necessary to organize effective services for this person, given his/her level of complexity and cultural background? • TEAM FUNCTIONING: To what degree: (1) Do members of the team collectively function as a unified team in planning services and evaluating results? (2) Do actions of the team reflect a coherent pattern of effective teamwork and collaborative problem solving that supports this person's recovery goals?

This review focuses on the structure and performance of the person's team in collaborative problem solving, providing effective services, and achieving positive results with the person. The team is composed of the person, care manager, guardian (if one is assigned), and any family members or any other persons invited by the person. Professionals providing treatment and paid service providers may comprise a service/support team for the person. Broad team representation may be recommended to assure that a necessary combination of technical skills, cultural knowledge, and personal interests are formed and maintained for the person. Collectively, the team should have the technical and cultural competence, knowledge of the person, authority to act in behalf of funders and to commit resources, and ability to flexibly assemble supports and resources in response to specific needs. Members of the team should have the time available to fulfill commitments made to the person. Team functioning and decision-making processes should be consistent with the principles of person-centered practice and integrated system of care operations. Evidence of effective team functioning lies in its performance over time and in the results it achieves for the person. The focus and fit of services, authenticity of relationships and commitments, unity of effort, dependability of service system performance, and connectedness of the person to critical resources all derive from the functioning of the family team. Present status, participation and perceptions, and achievement of effective results are important indicators about the functionality of the service team and should be taken into account when making this review.

Determine from Informants, Plans, and Records

1. Is the person along with professionals, funders, and others planning and guiding services? Are people with similar backgrounds to the person on the team? Which members did the person invite to participate? Does the person believe that these are the "right people" for him/her?

2. Is the person satisfied with the functioning of the team? Can the person request a team meeting at any time? Do all parties believe that they are fully aware of how the person's recovery is progressing?

3. Does the team have a common conceptualization of the needs of the person? Do the goals and objectives set by the team reflect the values of the person?

4. Do team members commit and ensure dependable delivery of services and resources for the person? Are all members of the team kept fully informed of the status and implementation of planned services?

5. Are team decisions coherent in design with efforts unified across all service agencies involved with the person? Does the team have and use flexible funding, informal resources, and generic services as appropriate to the permanency goal and planned safe case closure requirements, strategies, and activities?

6. Do team actions and decisions reveal a pattern of consistent and effective problem solving for this person? What are the present results?

Facts Used in Rating Performance

NOTE:

1. *Effective teamwork provides unity of effort across service providers and supporters in helping the consumer to plan and meet personal recovery goals.*

2. *Effective team work establishes and maintains situational awaress of the consumer's status, changing circumstances, and progress toward recovery goals.*

3. *Effective teams generally include service providers and supporters of the consumer who form a circle of support for the person's recovery.*

PRACTICE REVIEW 2: TEAMWORK

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Service Team | Rating Level

- **Optimal Team.** FORMATION: All of the "right people" for this person have formed an excellent working team that meets, talks, and plans together. The team has excellent skills, knowledge, and abilities necessary to organize effective services for a person with this complexity and cultural background. FUNCTIONING: Members of the team collectively function as a fully unified and consistent team in planning services and evaluating results. Actions of the team fully reflect an excellent coherent pattern of effective teamwork and fully collaborative problem solving that optimally benefits the person. The person is fully involved in the team.

  6
  ☐ Formation
  ☐ Functioning

- **Good Team.** FORMATION: Most of the "right people" for this person have formed a good and dependable working team that meets, talks, and plans together. The team has good and necessary skills, knowledge, and abilities necessary to organize effective services for a person of this complexity and cultural background. FUNCTIONING: Members of the team generally function as a substantially unified and consistent team in planning services and evaluating results. Actions of the team consistently reflect a substantially coherent pattern of effective teamwork and generally collaborative problem solving that generally benefits the person. The person is fully involved in the team.

  5
  ☐ Formation
  ☐ Functioning

- **Fair Team.** FORMATION: Some of the "right people" for this person have formed a minimally adequate to fair working team that meets, talks, and plans together. The team has minimally adequate to fair skills, knowledge, and abilities necessary to organize effective services for a person of this complexity and cultural background. FUNCTIONING: Members of the team may function as a somewhat unified and consistent team in planning services and evaluating results. Actions of the team usually reflect a fairly coherent pattern of effective teamwork and somewhat collaborative problem solving that at least minimally benefits the person. The person is fully involved in the team.

  4
  ☐ Formation
  ☐ Functioning

- **Marginal Team.** FORMATION: Some of the "right people" for this person have formed a marginal working group that occasionally meets, talks, and plans together. The group has limited or inconsistently used skills, knowledge, and abilities necessary to organize effective services for a person of this complexity and cultural background. FUNCTIONING: Members may function as a somewhat splintered and inconsistent group in planning services and evaluating results. Actions of the group usually reflect a somewhat incoherent pattern of teamwork and limited collaborative problem solving that seldom benefits the person. The person is only marginally involved in the team.

  3
  ☐ Formation
  ☐ Functioning

- **Poor Team.** FORMATION: Few, if any, of the "right people" for this person may seldom meet, talk, and plan together. Persons involved with the person may have few or inconsistently used skills, knowledge, and abilities necessary to organize effective services for a person of this complexity and cultural background. FUNCTIONING: Members may often function independently and/or in isolation of other team members in planning services and evaluating results. Actions reflect a infrequent or rare pattern of teamwork or collaborative problem solving. This situation may limit benefits for the person. The person may not be involved in all aspects of the team.

  2
  ☐ Formation
  ☐ Functioning

- **Absent or Adverse Team. EITHER** there is no evidence of functional team for this person with all interveners working independently and in isolation from one another. **- AND/OR -** The actions and decisions made by the group are inappropriate, adverse, and/or antithetical to the guiding principles of person-centered practice, recovery, and system of care integration of services across agencies for the person.

  1
  ☐ Formation
  ☐ Functioning

PRACTICE REVIEW 3: ASSESSMENT & UNDERSTANDING

ASSESSMENT & UNDERSTANDING: To what degree: • Does the service team have a working understanding of the person's strengths and needs in the context of the person's recovery goals as well as underlying issues that must change for the person to have a safe and satisfying life and to fulfill desired adult roles? • Does the team understand the person's aspirations for personal power and control in his/her life? • Are diagnoses used for the person's treatment consistent with current understandings among providers? • Is the relationship between the diagnoses and the person's bio/psycho/social functioning in daily activities well understood? • Are any co-occurring conditions identified, including substance abuse?

As appropriate to the person's situation and life stage, a combination of clinical, functional, and informal assessment techniques should be used to determine the person's aspirations, capabilities, assets, needs, risks, underlying issues, service history, and social ecology. Once gathered, the information should be analyzed and synthesized (along with diagnostic results) to form a comprehensive therapeutic impression or "big picture understanding" of the person necessary to support recovery. This includes the person's behavioral symptoms and daily functioning within the environmental context and current social support networks. Assessments, both formal and informal, should be appropriate for the person's age, ability, culture, language or system of communication, and social ecology. New assessments should be performed promptly when goals are met, when emergent needs or problems arise, or when changes are necessary. New assessment findings should stimulate and direct modifications in strategies, services, and supports for the person. Recent monitoring and evaluation results should be used to update the big picture view of the person's situation. Members of the person's service team, working together, should synthesize their assessment knowledge to form a shared understanding of the person's situation and what must be done to support recovery. This provides a common core of team intelligence for unifying efforts, planning joint strategies, sharing resources, finding what works, and achieving a good mix and match of supports and services. Developing and maintaining a useful functional assessment and big picture understanding is a dynamic, ongoing process performed by the person's service team.

Determine from Informants, Plans, and Records

1. Do assessments and team understandings reflect the person's aspirations, recovery goals, and strengths to build up? Are assessments conducted in a variety of settings? What are the common understandings held by the team?

2. What diagnoses are used as the basis of clinical treatment, particularly medications, for this person? Has there been a recent change in diagnoses? On what observations, assessments, or evaluations are they based? Does the person know results of assessments? Does he/she believe that results are accurate?

3. Do assessments reveal the person's functional status and level of impairment? Do assessments reflect the person's education, work history, and life stage?

4. Are risks of harm assessed (e.g., suicidal/homicidal impulses; physically/sexually aggressive behavior; ability to maintain physical safety; risk of victimization, abuse, or neglect; high risk behaviors; self-injurious behaviors)?

5. Are co-occurring conditions present (e.g., substance use impairment; physical illness or disability; developmental disability; other psychiatric conditions; recent transient, stress-related, psychiatric symptoms)?

6. Are life stressors present (e.g., traumatic or enduring disturbing circumstances; recent life transitions; grief or losses of consequence; transient but serious illness or injury; expectations that create discomfort; danger or threat in daily settings; incarceration; extreme poverty; social isolation; language barrier)?

7. Does the team understand what intervention strategies work and don't work for the person? What does the person say works best for him/her?

Facts Used in Rating Performance

PRACTICE REVIEW 3: ASSESSMENT & UNDERSTANDING

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
8. How well do the team and person demonstrate an understanding of what things have to change to reduce symptoms and achieve recovery goals?	

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Assessment & Understanding**. The diagnoses used as a basis of treatment and recovery are well justified with history, symptom observations, assessments, and evaluations fully documented. Clearly delineated relationships exist between the treatment diagnoses, the person's bio/psycho/social functioning, his/her daily social contexts, and his/her goals and aspirations that are comprehensively understood by the person and staff/others involved in his/her supports and services. The full scope of things that must be changed in order for the person's symptoms/substance use to be reduced and for him/her to function adequately in normal daily settings are fully defined in the pursuit of recovery and thoroughly understood by the service team. **6** ☐

- **Good Assessment & Understanding.** The diagnoses used as a basis of treatment and recovery are generally supported with history, symptom observations, assessments, and evaluations documented. Demonstrated relationships exist between the treatment diagnosis, the person's bio/psycho/social functioning, his/her daily social contexts, and his/her goals and aspirations that are generally understood by the person and staff/others involved in his/her supports and services. Most of the things that must be changed in order for the person's symptoms/substance use to be reduced and for him/her to function adequately in normal daily settings are generally defined in the pursuit of recovery and understood by the service team. **5** ☐

- **Fair Assessment & Understanding.** The diagnoses used as a basis of treatment and recovery are minimally supported with history, symptom observations, assessments, and evaluations fully documented. Some reported relationships exist between the treatment diagnosis, the person's bio/psycho/social functioning, his/her daily social contexts, and his/her goals and aspirations that are somewhat understood by the person and staff/others involved in his/her supports and services. Some of the things that must be changed in order for the person's symptoms/substance use to be reduced and for him/her to begin the recovery journey are somewhat defined and minimally understood by the service team. **4** ☐

- **Marginal Assessment & Understanding.** The diagnoses used for treatment and recovery are limited or inconsistent. Relationships are assumed to exist between the treatment diagnosis, the person's bio/psycho/social functioning, his/her daily social contexts, and his/her goals and ambitions by the service team. Some confusion exists about things that must be changed in order for symptoms/substance use to be reduced, and there are some questions about whether recovery is possible for the person. Dynamic conditions may be present that limit the usefulness of present understandings. **3** ☐

- **Poor Assessment & Understanding.** The diagnoses used for treatment and recovery are obsolete, erroneous, or inadequate. Limited associations between the treatment diagnosis, the person's functioning, social contexts, and ambitions have been made. Uncertainties exist about things that must be changed for symptoms/substance use to be reduced, and there is almost no hope for recovery. Dynamic conditions may be present that could require a fundamental reassessment of the situation. **2** ☐

- **Absent, Incorrect, or Adverse Assessment & Understanding.** Current diagnoses used for treatment and recovery are absent or incorrect. Some adverse associations between the treatment diagnoses, the person's functioning, daily social contexts, and life ambitions may have been made. Glaring uncertainties and conflicting opinions exist about things that must be changed for symptoms/substance use to be reduced, and recovery is not seen as possible. A new and complete functional assessment and big picture clinical impression should be developed and used now to move recovery and treatment planning forward for this person. **1** ☐

PRACTICE REVIEW 4: PERSONAL RECOVERY GOALS

PERSONAL RECOVERY GOALS (PRGs): To what degree: • Are there PRGs reflecting the person's life and career aspirations? • Do PRGs focus and guide the recovery/treatment process for this person?• If met, will these goals lead to the person managing successfully in daily settings, with supports and services as necessary, to achieve ongoing recovery?

Where is this person headed in life and how can his/her service team assist the person fulfill aspirations and achieve recovery? Will the current path of intervention lead to this person becoming more successful in daily functioning and being a part of the community? Will the person's recovery goals for guiding services that will lead to recovery? How were these goals determined? Who among the service providers actual knows and uses the person's PRGs to guide practice and service delivery toward the person's recovery?

PRGs form a guiding vision or long-term view used to set the purpose and path of recovery via intervention strategies and supports [taking the person's life stage into account]. It is used to frame a coherent recovery planning process for the person. PRGs focus and unify service planning efforts, especially when multiple interveners are involved. PRGs anticipate and define what the person must have, know, and be able to do in the recovery process leading to achievement of the person's ambitions and life goals. Smooth and effective transitions require such a strategic vision and its fulfillment through the service process. To be acceptable, the PRGs should "fit" the person's situation and establish a strategic course to be followed in a service process that will lead to achievement of recovery goals. Collectively, the PRGs should answer the questions of where is the intervention and support process headed for this person and why. Collectively, the PRGs should answer the question: How, where, and with whom will this person be living, learning, working, and socializing in the next 6-24 months? Meaningful answers to this question will support recovery for the person.

Determine from Informants, Plans, and Records

1. Are there PRGs for this person? If yes, are they explicitly written in the person's recovery plans? - OR - Are the PRGs implicitly understood as well as clearly and consistently articulated by members of the service team? Are they expressed in the person's own words? Can the person state his/her PRGs when asked?

2. Do the PRGs for this person take into account the persons's life stage, health condition, family situation (e.g., parent with minor children), personal interests and any specific court-ordered requirements or constraints?

3. Do the PRGs anticipate the next expected transition or life change for this person? If yes, does it set strategic goals aimed at enabling the person's successful life adjustment after crossing the transition threshold?

4. Do the PRGs cover functional areas: living, learning, working, and socializing? How much "say so" does the person have in setting PRGs in these areas?

5. Do the PRGs reflect the person's ambitions, goals, and preferences?

6. Do the PRGs reflect strengths, capabilities, risks, barriers, and needs?

7. If the PRGs are met, is the person likely to succeed in the recovery process, including making smooth and successful transitions and life adjustments, as necessary to have a more fulfilling life?

8. Are the person's PRGs updated as circumstances change? When important recovery thresholds are crossed, is the next one anticipated in the PRGs?

9. Will the person's current PRGs likely lead to greater independence, self-management, productivity, social integration, and community participation?

Facts Used in Rating Performance

NOTE:

Recovery goals focus on restorative change efforts aimed at returning the person to a previous state of higher functioning and well-being while lowering risks of impairment, social isolation, and harm.

For an elderly person who is becoming increasingly frail or for a person with a degenerative disease, the goals may focus on conservation of existing functioning and well-being in the near term.

For a person at life's end, the goals may focus on care and comfort until the person expires. In such cases, long-term recovery is not possible.

For a person who is presently incarcerated but will be returning to the community within the next 12 months, PRGs must reflect transition and adjustment to life in the community, compliance with parole requirements, career development/employment, housing, and social re-integration.

PRGs should be appropriate to the person's life stage, interests, circumstances, and any court-ordered requirements or constraints. To be useful in practice, PRGs must be realistic, recovery-focused, and attainable.

PRACTICE REVIEW 4: PERSONAL RECOVERY GOALS

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Personal Recovery Goals.** The person has explicitly expressed PRGs that are clearly and fully guiding recovery and that are fully understood by the person and service team members. Where appropriate, the PRGs fully envision the person's next major life changes/adjustments and articulate what the person must have, know, and be able to do to be successful when those recovery thresholds are crossed. The PRGs fully reflect the person's strengths, ambitions, preferences, barriers, needs and any court orders. The PRGs build upon knowledge of recent recovery milestones and are modified continuously as experience is gained and circumstances change. **6** ☐

- **Good Personal Recovery Goals.** The person has well understood (explict or implicit) PRGs that are substantially guiding recovery and that are generally understood among service team members. Where appropriate, the PRGs substantially anticipate the person's next major life changes/adjustments and articulate what the person must have, know, and be able to do to be successful when that recovery threshold is crossed. The PRGs substantially reflect the person's strengths, ambitions, preferences, barriers, needs and any court orders. The PRGs track recent recovery milestones and are modified frequently as experience is gained and circumstances change. **5** ☐

- **Fair Personal Recovery Goals.** The person has a written set of treatment/rehabilitation goals that creates implicit PRGs used by service team members. Where appropriate, the PRGs minimally anticipate the person's next major life changes/adjustments and identify some key elements that the person must have, know, and be able to do to be successful when that recovery threshold is crossed. The PRGs minimally reflect the person's ambitions, preferences, needs and any court orders. The PRGs periodically note recovery milestones and are updated as major circumstances change. **4** ☐

- **Marginal Personal Recovery Goals.** The person may have some vague or general long-term goals set by one or more funding agencies that create a limited planning direction for recovery. Set by others rather than by the person, these goals may inconsistently anticipate the person's next recovery stage, providing a few simple steps and provisions that may increase the likelihood of a successful future recovery. Existing goals only marginally reflect the person's ambitions or preferences. Existing goals may be limited or inconsistent in reflecting expected recovery milestones. Any court-ordered requirements or constraints may be marginally understood by the team and reflected in the person's treatment goals. **3** ☐

- **Poor Personal Recovery Goals.** The person may have a few treatment or servivce objectives set by one or more funding agencies, but they do not form a useful direction for recovery nor reflect the person's ambitions and life aims. The goals provide some simple steps or direction for service provision but are not necessarily linked to the person's recovery. Any court-ordered requirements or constraints may not be understood by the team nor reflected in the person's treatment goals. **2** ☐

- **Absent, Ambiguous, or Adverse Personal Recovery Goals.** There is no common future planning direction that is desired by the person and used by service team members to guide the person's recovery. Goals do not address the requirements that would increase the likelihood of successful recovery. Conflicting goals may be present and, if implemented, could lead to adverse consequences for the person. Any court-ordered requirements or constraints may be unknown or ignored by the team—an oversight that could disrupt the treatment process and preempt recovery efforts. **1** ☐

PRACTICE REVIEW 5: RECOVERY PLANNING

PLANNING: • To what degree is person-centered, team-driven, ongoing, recovery-focused planning used for selecting and organizing intervention strategies, actions, resources, and schedules to drive intervention processes forward to help meet the person's recovery goals?

This indicator focuses on how well the strategies, actions, resources, and schedules of the intervention/recovery processes used for this person are being **planned and organized** by those involved (team) in helping the person achieve his/her personal recover goals (PRGs). As necessary for the person to achieve recovery, a specifically arranged combination and sequence of interventions should lead to: (1) reduction of psychiatric symptoms and/or substance use; (2) recovery and relapse prevention; (3) adequate income and/or entitled benefits; (4) sustainable living supports; (5) social integration; and/or (6) successful transitions and life adjustments. The PRGs used for intervention planning define the destination points in the journey of recovery by framing the necessary outcomes. Intervention strategies are precisely matched to life changes, life stage, and recovery outcomes in the PRGs.

For each PRG to be met by or with the person, one or more intervention strategies are selected to achieve specific changes linked to attainment of recovery aims. Team members specify the strategies, actions, resources, timelines, and persons who are to be accountable for supporting the intervention and recovery processes by completing certain written agreements or plans made by participating agencies working with the person. Various agencies participating in and supporting recovery interventions have their respective agreements or plans. [For example: Child welfare may have a plan aimed at safety, permanency, and well-being of the person's minor children. Vocational Rehabilitation may provide an Individualized Written Rehabilitation Plan for service provided to the person. Behavioral health/addiction treatment services may provide a treatment/recovery plan. Probation/parole may have a court-ordered plan.] A given person may have multiple written documents by various agencies used to provide change strategies. Planning is specific to each intervention strategy. A safety or crisis response strategy assigns certain persons in a given setting to perform protective actions in response to a triggered risk event or condition. A learning strategy provides instruction, reinforced practice, and performance demonstration of skill proficiency in an appropriate setting. A housing strategy provides an actor to assist the person in securing Section-8 housing by making application, securing deposits, and covering moving expenses. The expectation here is that representatives of participating agencies are actively supporting recovery strategies for the person. Each representative prepares any written agreements or plans required by the agency to support recovery interventions and service efforts being funded or ordered by that agency. The focus of review is placed on planning and organization of the recovery intervention process, not any single "plan".

Determine from Informants, Plans, and Records

1. What specific intervention/recovery strategies are planned with and for the person? Which agencies are/should be responsible for each recovery strategies? Are evidenced-based practices being used? Is the provider competent in evidence-based practices, e.g., fidelity assurance, knowledge of contraindications, measurable objectives?

2. Which of the following life change/recovery areas have strategies for:
   - Reducing symptoms/substance use?
   - Supporting recovery and relapse prevention?
   - Securing income/benefits?
   - Securing sustainable living supports?
   - Improving social integration?
   - Staging successful transitions and life adjustments?
   - Meeting any requirements or constraints ordered by a court, including probation/parole

3. Do planning details offer the following for each change strategy:
   - The service actions to be provided to execute the change strategy?
   - The agency and persons who will be responsible for these service actions?
   - The timelines to be followed in implementation and progress reporting?
   - The authorization of services and resources necessary for implementation?
   - A way of knowing whether the strategy is working or not working?

4. Has the responsible person for representing each participating agency prepared/executed the necessary service agreement/plan with/for the person? Are goals/strategies aligned across agencies and plans for this person? Are they appropriate to life stage?
5. How well are strategies linked to specific actions for change? How well is coherence and consistency being achieved in the planning process? How well do the combination and sequence of strategies, services, and actions fit the person's situation, including his/her language, culture, life-stage, physical status, and legal status?
6. To what degree is daily practice actually driven by the planned change strategies? Does the planning process have a sense of urgency in working toward successful recovery and independence from the service system?
7. Is a treatment/care plan complete and available to all who need to know, including the person? Was the necessary plan/authorizing document developed by each funding agency? Does treatment/care plan coordinate with the strengths and needs assessment?
8. Has special procedure assessments been completed, e.g., level of care; suicide risk assessment; safety planning, critical transition points (admission, discharge, change in status, anti-depressant medications); and restraint/seclusion?

Facts Used in Rating Performance

NOTES:

Remember that strategies and resources of several agencies may have to be aligned and coordinated via planning and organization. These strategies, services, and resources may include those related to:

- *Early intervention (IFSP) to prevent or reduce developmental delays or disabilities of at-risk infants and toddlers (the person's child);*
- *Specialized rehabilitation, treatment, or training of persons experiencing physical, developmental or emotional disabilities (IWRP);*
- *Safety, permanency, and well-being of the person's children who have experienced maltreatment;*
- *Reduction of emotional/behavioral symptoms with concurrent improvements in coping skills, recovery, or improvement of daily functioning for persons with psychiatric/behavioral disorders;*
- *Gaining and maintaining sobriety for persons whose substance use is debilitating;*
- *Recovery and relapse prevention supports;*
- *Safety or crisis response in special situations;*
- *Promoting lawful behavior of offenders, payment of restitution, completion of community service, and complying with probation/parole orders;*
- *Career training and develop and transition to employment (TANF Work Force Development).*

PRACTICE REVIEW 5: RECOVERY PLANNING

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for Applicable Areas for Recovery Interventions — Rating Level

◆ **Optimal Recovery Planning & Service Organization.** An excellent, well-reasoned, continuous planning process is being fully used to provide *[as necessary]* for: (a) reduction of psychiatric symptoms and/or substance use; (b) recovery and relapse prevention; (c) securing income and/or entitled benefits; (d) acquiring sustainable living supports; (e) increasing social integration; and/or (f) successful transitions and life adjustments. Planning provides for precise use of change strategies, actions, timelines, and an accountable funder/provider for each change strategy used in the intervention process for achieving the person's recovery goals. Where necessary, strategies may be fully aligned and actions well-integrated across providers and funding sources. Daily practice is being fully driven by the planning process, bringing a great sense of urgency to actions taken to achieve recovery goals.

6

☐ a. Sym/SA reductn
☐ b. Recovery/relapse
☐ c. Income/benef
☐ d. Sust. supports
☐ e. Soc. integration
☐ f. Transition/adjust

◆ **Good Recovery Planning & Service Organization.** A generally well-reasoned, ongoing planning process is being substantially used to provide *[as necessary]* for: (a) reduction of psychiatric symptoms and/or substance use; (b) recovery and relapse prevention; (c) securing income and/or entitled benefits; (d) acquiring sustainable living supports; (e) increasing social integration; and/or (f) successful transitions and life adjustments. Planning provides for thoughtful use of change strategies, actions, timelines, and an accountable funder/provider for each change strategy used in the intervention process for achieving the person's recovery goals. Where necessary, strategies may be substantially aligned with actions generally integrated across providers and funding sources. Daily practice is being substantially driven by the planning process, bringing a good sense of urgency to actions to achieve the person's goals.

5

☐ a. Sym/SA reductn
☐ b. Recovery/relapse
☐ c. Income/benef
☐ d. Sust. supports
☐ e. Soc. integration
☐ f. Transition/adjust

◆ **Fair Recovery Planning & Service Organization.** A somewhat reasoned, periodic planning process is being at least minimally used to provide for:(a) reduction of psychiatric symptoms and/or substance use; (b) recovery and relapse prevention; (c) securing income and/or entitled benefits; (d) acquiring sustainable living supports; (e) increasing social integration; and/or (f) successful transitions and life adjustments. Planning provides for minimal use of change strategies, actions, timelines, and an accountable funder/provider for each change strategy used in the intervention process. Where necessary, strategies may be minimally aligned with actions somewhat integrated across providers and funding sources. Daily practice is being somewhat driven by the planning process, bringing a minimal to fair sense of urgency.

4

☐ a. Sym/SA reductn
☐ b. Recovery/relapse
☐ c. Income/benef
☐ d. Sust. supports
☐ e. Soc. integration
☐ f. Transition/adjust

◆ **Marginal Recovery Planning & Service Organization.** A marginally reasoned, occasional planning process is being inconsistently used to provide *[as necessary]* for: (a) reduction of psychiatric symptoms and/or substance use; (b) recovery and relapse prevention; (c) securing income and/or entitled benefits; (d) acquiring sustainable living supports; (e) increasing social integration; and/or (f) successful transitions and life adjustments. Planning provides for limited or inconsistent use of change strategies, actions, timelines, and an accountable funder/provider for each change strategy used in the intervention process for achieving family independence and safe case closure. Where necessary, strategies may be marginally or inconsistently aligned with little sense of urgency for action.

3

☐ a. Sym/SA reductn
☐ b. Recovery/relapse
☐ c. Income/benef
☐ d. Sust. supports
☐ e. Soc. integration
☐ f. Transition/adjust

◆ **Poor Recovery Planning & Service Organization.** A poorly reasoned, inadequate planning process is failing to provide *[as necessary]* for: (a) reduction of psychiatric symptoms and/or substance use; (b) recovery and relapse prevention; (c) securing income and/or entitled benefits; (d) acquiring sustainable living supports; (e) increasing social integration; and/or (f) successful transitions and life adjustments. Planning does not provide for adequate use of change strategies, actions, timelines, and an accountable funder/provider for each change strategy used in the intervention process for achieving the person's recovery goals. Where necessary, strategies may be not be aligned with actions nor integrated across providers and funding sources. Daily practice is not being driven by the planning process.

2

☐ a. Sym/SA reductn
☐ b. Recovery/relapse
☐ c. Income/benef
☐ d. Sust. supports
☐ e. Soc. integration
☐ f. Transition/adjust

◆ **Absent or Misdirected Planning. EITHER:** No clear planning process is operative at this time to provide *[as necessary]* for: (a) reduction of psychiatric symptoms and/or substance use; (b) recovery and relapse prevention; (c) securing income and/or entitled benefits; (d) acquiring sustainable living supports; (e) increasing social integration; and/or (f) successful transitions and life adjustments. **- OR -** Any planning activities may be substantially misdirected, conflicting, or insufficient in thought or detail to drive an effective intervention process toward attainment of recovery goals.

1

☐ a. Sym/SA reductn
☐ b. Recovery/relapse
☐ c. Income/benef
☐ d. Sust. supports
☐ e. Soc. integration
☐ f. Transition/adjust

◆ **Not Applicable.** One or more planning areas does not apply at this time.

NA

☐ a. Sym/SA reductn ☐ b. Recovery/relapse ☐ c. Income/benef
☐ d. Sust. supports ☐ e. Soc. integration ☐ f. Transition/adjust

PRACTICE REVIEW 6: RESOURCES

RESOURCES: • Are the resources (both informal and formal) necessary to action the strategies selected to meet the person's recovery goals available to and used by the person, interveners, and service team? • Is access and use of these resources of sufficient quality, quantity, duration, and intensity to meet the person's recovery goals on a timely basis? • Are any unavailable but necessary resources or supports identified by the team? • Are reasonable efforts being undertaken by the team to secure or develop any needed but unavailable supports, services, or resources?

A combination and sequence of intervention services and supports (formal and informal) and the resources (including authorization and funding) necessary to provide them are required to meet the person's recovery goals. Supports can range from volunteer reading tutors, peer mentors, recreational activities, and supported employment. Supports may be voluntarily provided by friends, neighbors, and churches or secured from provider organizations. Professional treatment services may be donated, offered through health care plans, or funded by government agencies. A combination of supports and services may be necessary to support and assist the person meet his/her recovery goals. For clinical or rehabilitative service providers to exercise professional judgment and for the person to exercise choice in the selection of treatment services and supports, an array of appropriate alternatives should be locally available. Such alternatives should present a variety of socially or therapeutically appropriate options that are readily accessible, have the power to produce desired results, be available for use when and as needed, and be culturally compatible with the needs and values of the person. An adequate array of services includes social, health, mental health, substance abuse treatment, educational, vocational, recreational, peer support, and organizational services, such as care coordination. An adequate array spans supports and services from all sources that may be needed by the person. Selection of basic supports should begin with informal network supports and generic community resources available to all citizens. Specialized and tailor-made supports and services should be developed or purchased only when necessary to supplement rather than supplant readily available supports and services of a satisfactory nature. Unavailable resources should be systematically identified with reasonable efforts made by the service team to secure or develop any needed but unavailable supports, services, or resources.

Determine from Informants, Plans, and Records

1. Are those resources necessary to implement intervention strategies in the following recovery areas available, adequate, and used to meet the recovery goals for this person?

   - Reducing symptoms/substance use?
   - Supporting recovery and relapse prevention?
   - Securing income/benefits?
   - Securing sustainable living supports?
   - Improving social integration?
   - Staging successful transitions and life adjustments?

2. To what extent are clinical intervention resources necessary for this person's treatment and recovery accessible, available, adequate, dependable, and sufficient for reducing psychiatric symptoms and/or substance abuse? Have any indicated services been denied or cut-off?

3. As necessary to meet any recovery goals for securing income, employment, entitled benefits, sustainable living supports, social integration, and transitions -- what resources are being used for this person? How are available and dependable are resources in these areas?

4. Did the person have two or more appropriate and attractive options from which to choose when selecting current recovery-oriented services and social supports?

5. Have informal supports been developed or uncovered and used at home, at work and in the community as a part of the recovery planning and resourcing process?

6. To what extent are informal resources of the family, extended family, neighborhood, civic clubs, churches, charitable organizations, local businesses, and general public services (e.g., recreation, public library, or transportation) used in providing supports? Were any of the supports and services tailor-made or assembled uniquely for this person? Are they sustainable as needed over time? Do these resources match the person's stage of life?

7. Is the service team taking steps to locate or develop or advocate for any currently needed resources that are not now available, adequate, or sufficient for effective use?

Facts Used in Rating Performance

NOTES

This indicator focuses on the combination of resource availability and use in driving a successful intervention and recovery process for the person being reviewed.

Consider the person's life stage and the resources that are necessary for that stage of life.

Resource identification and use patterns tend to reflect what staff know of and know how to easily access and use. Explore what resources that staff know/don't know about that could used to better meet this person's recovery goals.

Assignment to a waiting list, exhaustion of a service authorization without goal attainment when substantial progress is being made, and stopping an effective service when substantial progress is being made toward goal attainment when an arbitrary time limit has been reached are all fundamental problems in resource availability or adequacy.

If treatment or support services necessary to meet recovery goal are not available, adequate, or sufficient for this person, report what is missing and the reasons given.

PRACTICE REVIEW 6: RESOURCES

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
8. Is the combination and sequence of intervention services and support used for/by this person dependable and satisfactory from the person's point of view?	
9. Have the person and the service team taken steps to identify resource gaps, develop or secure resources, and notify the community of development needs?	

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Resources.** An excellent array of supports and services is available to help the person reach optimal levels of functioning necessary for him/her to make optimal progress toward recovery. A highly dependable combination of informal and, where necessary, formal supports and services is appropriate, used, and seen as very satisfactory by the person. The array offers a wide range of options that permits use of professional judgment and the person's experience about appropriate treatment and consumer choice of providers. **6** ☐

- **Good Resources.** A substantial and dependable array of supports and services is available to help the person reach favorable levels of functioning necessary to make good progress toward recovery. A usually dependable combination of informal and formal supports and services is available, appropriate, used, and seen as generally satisfactory by the person. The array provides a good range of options that enables use of professional judgment, the person's experience, and consumer choice of providers. Steps are being taken to secure or develop additional resources to give the person greater choice and/or provide resources to meet any unmet needs. **5** ☐

- **Fair Resources.** A basic array of supports and services is available to help the person reach minimally acceptable levels of functioning necessary for him/her to make fair progress toward recovery. A set of supports and services is usually available, somewhat appropriate, used, and seen as minimally satisfactory by the person. The array provides few options, limiting professional judgment and consumer choice in the selection of providers. Steps are being considered to mobilize additional resources to give the person greater choice and/or provide resources to meet particular unmet needs, but no steps have been undertaken. **4** ☐

- **Marginal Resources.** A adequate array of supports and services may not be consistently available to help the person reach levels of functioning necessary for him/her to make progress toward recovery. These supports and services may be inconsistently available and may be seen as partially unsatisfactory by the person. The array provides few options, substantially limiting use of professional and consumer judgment and personal choice in the selection of providers. Steps to mobilize additional resources to give the person greater choice and/or provide resources to meet particular unmet needs have not yet been considered. **3** ☐

- **Poor Resources.** An inadequate or insufficient array of supports and services is limiting the person's opportunity to make progress toward recovery. Few supports and services may be available, dependable, and/or used. Available services may be seen as generally unsatisfactory by the person. The sparse array or limited authorization rules (or denials/terminations of service) provides very few options or services that are woefully underpowered to meet recovery goals. No effort to address resource problems has been planned or undertaken by the person or team. The person may not have a functioning service team. **2** ☐

- **Missing or Undependable Resources.** Few, if any, appropriate, adequate, or dependable services or supports are provided or used. They may not fit the actual needs of the person well and may be undependable over time. Because informal supports may not be well developed and/or because local services or funding is limited, any services may be offered on a "take it or leave it" basis. The person may be dissatisfied with or refuse services, and lack of service may present a potential risk to the person and/or community. The person and team may be powerless to alter the service availability or use situation or the person may lack a functioning service team at this time. **1** ☐

PRACTICE REVIEW 7: INTERVENTION ADEQUACY

INTERVENTION ADEQUACY: To what degree are the recovery-related interventions, actions, and resources provided to the person of sufficient power (precision, intensity, duration, fidelity, and consistency) required to produce results necessary to achieve the person's recovery goals?

The purpose of intervention is bringing about successful recovery processes for the person. As necessary to meet the person's recovery goals (PRGs) , a specifically arranged combination and sequence of interventions leads to:(1) reduction of psychiatric symptoms and/or substance use; (2) recovery and relapse prevention; (3) adequate income and/or entitled benefits; (4) sustainable living supports; (5) social integration; and/or (6) successful transitions and life adjustments. These PRGs define the destination points of the the person's recovery journey by framing the desired outcomes ("how you will know when you are done") necessary for the person to function successfully independent of system intervention. Driving planned intervention processes successfully to meet the PRGs often requires a combination and sequence of informal supports and formal interventions to meet change requirements. Each planned change is driven by one or more specific strategies that must be actioned, resourced, and coordinated in the proper combination, sequence, duration, and intensity to achieve the desired results. The driving forces for specific changes must have power (i.e., appropriate strategy combination, sequence, duration, intensity, continuity, coordination, precision/fidelity in delivery, and demonstration of efficacy) commensurate with that required to bring about the desired change and to sustain that change over time to reach and sustain recovery. The central principle and moral imperative of practice is to find what works. The purpose of this review is determining the extent to which the combination of intervention strategies being used for the person demonstrates that the power of planned interventions is commensurate with the changes required for successful recovery. The reviewer should consider what is required to bring about changes that lead to recovery for the person. What is required may include use of evidence-based practice strategies and related fidelity criteria or measures applied to ensure adequate implementation for desired effect.

- Level of intensity, duration, coordination, and continuity necessary to produce the changes necessary for change with sustained success leading to successful independence from the system, successful transitions, and safe case closure. This consideration should be based on what is required for successful and sustained change, without regard for any service authorization limitations.

- Demonstration of progress toward attainment of desired results and attainment of PRGs. Adequacy of intervention power must be considered in light of its effectiveness in driving the change process in the desired direction toward goal attainment. Lack of expected progress suggests that planned strategies are either the "wrong" strategies or that the "right" strategies are underpowered.

The answer to the question of what is working and not working in a person's recovery often depends on the adequacy of intervention.

Determine from Informants, Plans, and Records

1. What are the specific strategies being used in the change process for this person? What is required for precise delivery (for desired effect) for each strategy?

2. Is the level of intensity, duration, coordination, and continuity commensurate with what is required for successful and sustained recovery? If not, are current service authorization rules or limitations leading to discontinuity or inadequacy of effect? Do the strategies match the changes to be made? What working/not working now?

3. Are service providers adequately trained, prepared, coordinated, and supervised?

4. Are any and all urgent needs met in ways that protect the health and safety of the person or, where necessary, protect others from the person?

5. Which, if any, intervention strategies are not working at this time? Are there any intervention strategies for this person that cannot be adequately: 1) actioned with precision, 2) resourced sufficiently, 3) coordinated consistently, or 4) delivered with continuity?

NOTE:

*In the era of evidence-based practice, greater precision is required to **"match strategy to change"** rather than the traditional approach of simply matching service to need.*

Use of precise strategies to bring about specific changes requires that: (1) strategies are precisely matched to the changes to be made via the interventions used; (2) interventions are adequately powered and executed appropriately for achieving and sustaining change; and (3) change is demonstrated to test strategies for effectiveness and for the careful management of the recovery process via results-driven decision making.

PRACTICE REVIEW 7: INTERVENTION ADEQUACY

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Intervention Power.** An excellent combination, sequence, and power of current interventions is helping the person reach optimal levels of functioning necessary for him/her to make progress toward PRGs. An excellent combination of informal and, where necessary, formal supports and interventions is provided with excellent precision and with fully commensurate levels of intensity, duration, continuity, and coordination. The power of intervention is fully sufficient to quickly, fully reach or exceed all of the outcomes necessary for this person to achieve and sustain recovery. — **6** ☐

- **Good Intervention Power.** A good combination, sequence, and power of current interventions is helping the person reach good and substantial levels of functioning necessary for him/her to make progress toward PRGs. A highly dependable combination of informal and, where necessary, formal supports and interventions is provided with good precision and with substantially commensurate levels of intensity, duration, continuity, and coordination. The power of intervention is generally sufficient to generally reach most of the outcomes necessary for this person to achieve and sustain recovery. — **5** ☐

- **Minimally Adequate to Fair Intervention Power.** A fair combination, sequence, and power of current interventions are somewhat helping the person reach minimally adequate to fair levels of functioning necessary for him/her to make progress toward PRGs. A minimally adequate combination of informal and, where necessary, formal supports and interventions is provided with some precision and with at least minimally adequate levels of intensity, duration, continuity, and coordination. The power of intervention is minimally adequate to reach some of the outcomes necessary for this person to achieve and maintain recovery. — **4** ☐

- **Marginal Intervention Power.** A somewhat underpowered combination and sequence of current interventions is marginally helping the person reach somewhat inadequate or inconsistent levels of functioning necessary for him/her to make progress toward PRGs. A marginal combination of informal and, where necessary, formal supports and interventions is provided with little precision and somewhat inadequate levels of intensity, duration, continuity, and coordination. The power of intervention is not sufficient to reach some of the most important outcomes necessary for this person to achieve and maintain recovery. — **3** ☐

- **Poor Intervention Power.** A very limited combination, sequence, and power of current interventions are not helping the person reach levels of functioning necessary for him/her to make progress toward PRGs. A poor and insufficient combination of informal or formal supports and interventions is provided without precision and without adequate levels of intensity, duration, continuity, and coordination. The power of intervention is not adequate to reach many of the outcomes necessary for this person to achieve and maintain recovery. — **2** ☐

- **Absent or Adverse Intervention Power. EITHER:** (1) Currently planned interventions are not being implemented; **- OR -** (2) The wrong interventions are being implemented without desired effect and/or with adverse effects; **- OR -** (3) Potentially successful interventions are provided but are underpowered to achieve desired effects. **OR --** The state-of-the art in recovery interventions does not offer strategies that are capable of assisting this person's recovery. — **1** ☐

PRACTICE REVIEW 8: URGENT RESPONSE

URGENT RESPONSE: • Is there timely access to and provision of effective services to stabilize or resolve emergent or episodic problems, as needed by this person? • Are crisis services accessed and delivered in a manner that respects and does not demean the person?

NOTE: This examination applies only to a person who by history has a demonstrated need for these services.

A person who presents dangerous psychiatric symptoms, severe maladaptive behaviors, or acute episodes of chronic health problems (e.g., seizures, hemophilia, asthma) may require immediate, specific, and possibly intensive services to meet emergent needs and to prevent harm from occurring to the person or to others. For such persons, an urgent response capability is necessary. Providing this capacity requires a health or safety "crisis plan," designed specifically for the person, that can be activated and implemented immediately. An alert procedure and crisis response capability has to be prepared in advance, has to be made a part of the crisis response or safety plan, and has to be prepared to implement the crisis response plan and a follow-along mechanism that tracks the person through the crisis period. The urgency and significance of an emerging need or problem of the person should be met with a timely and commensurate service response (i.e., **emergency** within one hour and **urgent** within 24 hours). The primary concern here is whether the person, members of his/her support system, and service workers have timely access to services necessary to stabilize or resolve emerging problems of an urgent nature. A person living in a home under adult protective supervision may require a safety plan to be followed in the event of domestic violence, abandonment, or some other safety problem that has occurred previously in the home. A crisis plan should be evaluated following every use to ensure that its provisions are effective and that persons responsible for its use know and perform key tasks. This review applies to a person who has experienced an episode requiring urgent response within the past six months or who is at high risk of such an episode.

Determine from Informants, Plans, and Records

To determine if this review area should be rated, consider the following matters:

- ☐ **Does the person present severe levels of psychiatric symptoms or behavioral challenges? If so, do these symptoms present cyclically? Can crisis episodes be anticipated?**
- ☐ **Does the person have a chronic health condition with frequent acute episodes that needs to be taken into account in planning behavioral health services?**
- ☐ **Is this person's home under adult protective supervision or threat of closure?**
- ☐ **Have special risks* and a pattern of urgent needs been identified for this person?**
- ☐ **Are safety plans indicated and provided to manage special situations?**
- ☐ **Have emergency procedures (including 911 services) been used for this person?**

1. Does this person have a crisis alert and response plan? If so, how is it designed?
2. Are emergent or urgent response services available when and as needed? Have emergent or urgent response services ever been denied? If so, why?
3. Is there an alert procedure, crisis response plan, or advance care directive for this person specified in appropriate plan documents? Are the persons who would send the alert and implement the crisis response plan aware of and ready to fulfill their assigned responsibilities? How is it working now?
4. Have the alert and crisis response processes been used in the past six months for this person or caregiver? If yes, did they work effectively? Were such services timely (within one hour, if an emergency, and within 24 hours, if urgent)?
5. Is there an advance directive the person can follow or initiate? Has the plan been developed collaboratively with the person? How current is the plan?

Facts Used in Rating Performance

**Special Risks to Consider:*

- *Recent abuse, trauma, victimization*
- *Recent self-mutilation or self-injury*
- *Recent severe aggression toward others*
- *Domestic violence (perpetrator or victim)*
- *Under adult protective custody or supervision for abuse, neglect, dependency*
- *Resident in a facility with licensing problems*
- *Resident in an unlicensed facility*
- *Recent arrest, hospitalization, or self-endangering*
- *Significant external impact (e.g., loss of a loved one, parental divorce, homelessness)*
- *Recent change in medications, level of care, place of residence, or staffing*

NOTE

There are four dimensions of emergent/urgent need and response to consider in this indicator:

1. *Physical Health Crisis: this applies to a person who has a physical condition that can spiral out of control and require immediate action to preserve life (e.g., a brittle diabetic).*
2. *Behavioral Crisis: this applies to a person who may quickly decompensate into serious symptoms yielding behaviors that pose serious risk to self or others.*
3. *Relapse: Recurrence of addiction (binge).*
4. *Domestic Violence Episode: Repeating pattern.*

PRACTICE REVIEW 8: URGENT RESPONSE

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Urgent Response Capability.** The plan has been developed with the person and he/she has stated preferences for crisis management strategies that are followed/in use to the maximum extent possible. All appropriate supporters in the person's daily living, working, and therapeutic settings are fully prepared and ready to implement the team alert, crisis response, and follow-along provisions of a well-tested, effective, and respectful urgent response capability for the person. The alert and crisis response processes, if used in the past six months, performed in an excellent, reliable, respectful, and effective manner. **6** ☐

- **Good Urgent Response Capability.** The plan has been developed with the person and he/she has stated preferences for crisis management strategies that are followed, to a substantial degree, as circumstances permit. Key supporters in the person's daily living, working, and therapeutic settings are generally prepared and ready to implement the team alert, crisis response, and follow-along provisions of the person's urgent response plan. Plan provisions have been discussed and are believed to be adequate or, if used in the past six months, worked reliably, respectfully, and acceptably well. **5** ☐

- **Fair Urgent Response Capability.** The plan may have been designed based on the person's ideas and previous experiences. Key supporters in the person's daily living, working, and therapeutic settings are minimally prepared to implement the team alert, crisis response, and follow-along provisions of the person's urgent response plan. Plan provisions are periodically reviewed with the persons responsible for implementation. If used recently, crisis response was at least minimally successful in managing risks and securing necessary services and was not described by the person as disrespectful. **4** ☐

- **Marginal Urgent Response Capability.** The person was not involved in the development of the plan and may not even know of its existence. Some, but not all, of the key supporters in the person's daily living, working, and therapeutic settings are minimally prepared to implement the team alert, crisis response, and follow-along provisions of the person's urgent response plan. If used recently, crisis response revealed some minor problems in managing risks at an acceptable level or in securing necessary crisis services in an acceptable and respectful manner. **3** ☐

- **Poor Urgent Response Capability.** The person was not involved in the development of the plan and may not even know of its existence. Key supporters in the person's daily living, working, and therapeutic settings are not adequately prepared to implement a team alert, crisis response, and follow-along plan necessary for the person. If used recently, crisis response revealed substantial problems in managing risks at an acceptable level or in securing crisis services in an acceptable and respectful manner. **2** ☐

- **Absent or Adverse Urgent Response Capability.** A crisis plan and response is necessary for this person but currently may not exist (except to call 911). In any recent crisis, the crisis response effort failed to manage risks adequately or failed to provide crisis supports or services in an acceptable and respectful manner to the person. **1** ☐

- **Not Applicable.** The person has no history of psychiatric or medical crises or safety emergencies within the six months and presents little or no risk of such crisis situations at this time. **NA** ☐

PRACTICE REVIEW 9: MEDICATION MANAGEMENT

MEDICATION MANAGEMENT: • Is the use of psychiatric/addiction control medications for this person necessary, safe, and effective? • Does the person have a voice in medication decisions and management? • Is the person routinely screened for medication side effects and treated when side effects are detected? • Have new atypical/current generation drugs been tried, used, and/or appropriately ruled out? • Is the use of medication coordinated with other treatment modalities and with any treatment for any co-occurring conditions (e.g., seizures, diabetes, asthma/COPD, HIV)?

Use of psychiatric/addiction control medications is one of many treatment modalities that may be used in treating a person having a serious emotional disorder. When use of such medications is deemed necessary and appropriate, it should conform to standards of good and accepted practice, including informed consent, consultation, most efficacious drug selection, consistency with medication protocols, demonstrated treatment response, and minimal effective dose. Effects and side effects of medication use should be assessed, tracked, and used to inform decision making. Any adverse side effects should be addressed and treated. Use of medications should be coordinated with other modalities of treatment including positive behavioral supports, behavioral interventions, counseling, skill development, and social supports. Continuity in medication regimes should be present across treatment settings. The person should have access to necessary specialized health care services including treatment and care for any co-occurring conditions (e.g., seizures, asthma, diabetes, addiction, HIV). The purpose is to determine whether the person receives and benefits from safe medication practices. This review does not apply to a person who has not taken psychotropic medications within the past 90 days.

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
1. Does the person take a psychotropic/addiction control medication? Is use consistent with current treatment protocols? Has the person given consent for each medication?	
2. Is there a DSM-IV-R Axis I diagnosis to support each psychotropic medication? Is the purpose for each medication documented and tracked to target symptoms or maladaptive behaviors? Is each medication consistent with intended use?	
3. Has a minimum effective dosage of each medication been determined or are steps being taken to do so? Who is responsible for medication monitoring and screening for side effects?	
4. Is there periodic evaluation of the person's response to treatment using data to track target symptoms or behaviors?	
5. Is there quarterly screening of the person for adverse effects of medications? If adverse effects have been found, have appropriate countermeasures been implemented?	
6. Is medication use coordinated with other treatment modalities? If multiple psychotropic medications are used with the person, is there written justification by the physician? Is the primary care physician informed of these medications?	
7. Does the person have access to specialized health care services? Have coordinating staff consulted with other treating professionals (e.g., neurologists, psychiatrists) for a person having chronic and/or complex health care needs?	
8. Is relapse prevention information available to the person? Is educational information about medications, effects/side effects, and self-medication available?	
9. Has the person requested medication adjustments? Are the person's significant others trained on medications (e.g., administration, effects, side effects)?	

PRACTICE REVIEW 9: MEDICATION MANAGEMENT

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Medication Management.** The person presents symptoms or behaviors that are responding well to current generation medications with no report of bothersome side effects. The person reports good compliance with the prescribed medications and is not requesting any changes at this time. Use of medications is well coordinated with other treatment modalities. The person and physician have an understanding about how he/she is to manage increases/decreases in medications. The person has full and timely access to high quality health care for any serious health co-occurring conditions. — **6** ☐

- **Good Medication Management.** The person presents symptoms or behaviors that are responding fairly well to current generation medications but reports some mild side effects. The person reports that sometimes medications are not taken as prescribed. Use of medications is sometimes coordinated with other treatment modalities. The person and physician have an understanding about how he/she is to manage increases/decreases in medications. The person has full and timely access to high quality health care for any serious health co-occurring conditions. — **5** ☐

- **Fair Medication Management.** The person is becoming stable on appropriate medication and presents some symptoms or behaviors of concern and complains of side effects. Use of medication is checked conversationally and staff hint at non-compliance. The person may refuse participation in medication education activities. Medication is minimally coordinated with other treatment modalities. The person has minimally adequate access to fair quality health care for any serious health co-occurring conditions, including specialists with a short waiting period. — **4** ☐

- **Marginal Medication Management.** The person presents symptoms or behaviors that may be responding somewhat to medications. Medication use may be inconsistent. Consents may not have been obtained. Screening for side effects may not be current or mild side effects may be noted but minimally treated. Use of medication is seldom coordinated with other treatment modalities. The person has somewhat limited access to fair-to-poor quality health care for any serious health co-occurring conditions and may receive most care from emergency rooms. — **3** ☐

- **Poor Medication Management.** The person presents symptoms or behaviors that may not be responding to medications. Medication use may not be well documented or justified. Consents may be missing. Screening for side effects may not be current or moderate side effects may be noted. Use of medication is not coordinated with other treatment modalities. The person has inconsistent or very slow access to health care for any serious health co-occurring conditions. The person's physical or psychiatric status may be at risk due to inadequate health care for treating co-occurring conditions. — **2** ☐

- **Absent or Adverse Medication Management.** The person presents increasing symptoms or behaviors that may not be responding to medications. Medication use may be undocumented, not justified, or experimental. Consents may be missing. Screening for side effects may not occur or serious side effects may be present and untreated. Use of medication is conflicting with other treatment modalities. The person has poor or no access to needed health care for any serious health co-occurring conditions. The person's physical or psychiatric status may be declining due to inadequate health care. — **1** ☐

- **Not applicable:** The person does not now take psychotropic medications, nor has the person used such medications within the past 90 days. Therefore, this review does not apply. — **NA** ☐

PRACTICE REVIEW 10: SECLUSION/RESTRAINT

SECLUSION/RESTRAINT: • If emergency seclusion or restraint has been used for this person, was each use: (1) Done only in an emergency? (2) Done after less restrictive alternatives were found insufficient or impractical? (3) Ordered by a trained, authorized person? (4) Accomplished with proper techniques that were safely and respectfully performed by qualified staff? (5) Effective in preventing harm? and (6) Properly supervised during use and evaluated afterwards?

Respectful relationships, effective communications, and positive behavior management techniques help to create safe therapeutic environments and reduce the emergence of unsafe situations. Staff training, appropriate placements and transfers, and use of advanced directives also minimize the use of emergency control techniques to prevent harm. Special procedures are permitted only when the person is a danger to him/herself or others and when alternative interventions are impractical or insufficient. Use of these emergency measures must be implemented in the least restrictive manner possible and ended as quickly as possible. During implementation, the person's status and effects of the procedure must be continually assessed, monitored, and evaluated. Seclusion and certain forms of restraint (physical, legal, protective, and medical) may be used under specific conditions, but chemical restraint (medication to immobilize a person) is prohibited. Seclusion is not a treatment modality and is contraindicated for persons who exhibit suicidal or self-injurious behavior. Each use of seclusion or restraint must be ordered on a time-limited basis for a person. Such measures are never authorized by "standing orders" or on an "as needed" (PRN) basis. Certain forms of restraint are prohibited (e.g., restraining nets, ambulatory restraints, face-down restraints, simultaneous use of seclusion and restraint, renewal orders in excess of one hour, use of seclusion or restraints in excess of 24 hours, any restraint around a person's neck or covering the person's face). Restraint may be contraindicated for a person who has experienced sexual trauma or physical abuse or who is deaf and cannot communicate without the use of hands. Staff are to follow specific policies and procedures when using seclusion and restraint. All services, including emergency measures, should be provided with consideration and respect for the person's dignity, autonomy, and privacy. This review applies to a consumer who has experienced the use of an emergency control procedure within the past 90 days.

Determine from Informants, Plans, and Records

1. Has the person experienced the use of any emergency control technique within the past 90 days? If so, what were the circumstances of use? What was the emergency and risk of harm? What antecedent events were present? What alternative interventions were found insufficient or impractical at the time?

2. Were respectful relationships, effective communications, and positive behavior management techniques used at the facility to create safe therapeutic environments and reduce the emergence/recurrence of unsafe situations for the person?

3. Were staff training, appropriate placements and transfers, and use of advanced directives applied to minimize use of emergency control techniques?

4. Were the emergency measures implemented in the least restrictive manner possible and ended as quickly as possible? During implementation, were the person's status and effects of the procedure continually assessed, monitored, and evaluated ? If so, by whom? What do records reflect?

5. Were the forms of seclusion or restraint used with the person consistent with standards of good practice (not using any contraindicated or prohibited techniques) and consistent with the facility's policies and procedures?

6. How has the person's IRP been modified to reduce the use of special procedures, based on experience gained?

7. Has the rate of use of special procedures been reduced or eliminated?

8. Is relapse prevention information available to the person? Have advanced directives been used, evaluated, and modified over time, based on experience?

Facts Used in Rating Performance

Only licensed facilities with trained and well-supervised staff should use emergency control procedures and then only in conformance with policies and procedures. Monitoring of emergency control measures should be done via an internal quality improvement program.

PRACTICE REVIEW 10: SECLUSION/RESTRAINT

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Use of Special Procedures.** The person is served in an excellent therapeutic environment that reduces the emergence of unsafe situations via respectful relationships, effective communications, and positive behavioral supports. Excellent use of advanced directives, appropriate placements, and lesser restrictive techniques by highly trained staff minimizes use of special procedures, which, when used in an emergency, are the least restrictive, most appropriate, and most effective techniques possible. Staff actions are highly consistent with facility policies, procedures, and best practice. Based on experience gained, the person and team have modified the IRP and advanced directives to minimize unsafe situations. An excellent level of respect for the person's dignity, autonomy, and privacy is demonstrated by staff in the use of special procedures. **6** ☐

- **Good Use of Special Procedures.** The person is served in a generally positive therapeutic environment that reduces the emergence of unsafe situations via respectful relationships, effective communications, and positive behavioral supports. Good use of advanced directives, appropriate placements, and lesser restrictive techniques by well-trained staff minimizes use of special procedures, which, when used in an emergency, are the least restrictive, most appropriate, and most effective techniques possible. Staff actions are generally consistent with facility policies, procedures, and good practice. Based on experience gained, the person and team have modified the IRP and advanced directives to minimize unsafe situations. A good and consistent level of respect for the person's dignity, autonomy, and privacy is demonstrated by staff in the use of special procedures. **5** ☐

- **Fair Use of Special Procedures.** The person is served in a fairly positive therapeutic environment that helps to reduce the emergence of unsafe situations via respectful relationships, fair communications, and positive behavioral supports. Minimal use of advanced directives, appropriate placements, and lesser restrictive techniques by some trained staff lowers use of special procedures, which, when used in an emergency, may be the least restrictive, most appropriate, and most effective techniques possible. Staff actions are fairly consistent with facility policies, procedures, and accepted practice. Based on experience gained, the person and team may have modified the IRP and advanced directives. A minimal-to-fair level of respect for the person's dignity, autonomy, and privacy is demonstrated by staff in the use of special procedures. **4** ☐

- **Marginal Use of Special Procedures.** The person is served in a somewhat problematic environment, having limited or inconsistent relationships, communications, and behavioral supports. Use of advanced directives and lesser restrictive techniques is limited by gaps in staff training. Use of special procedures, which are used only in real emergencies, may not be the least restrictive, most appropriate, and most effective techniques possible. Staff actions are sometimes inconsistent with facility policies, procedures, and accepted practice. Experience gained may have little connection to modifications in the person's IRP or any advanced directives. A marginal and inconsistent level of respect for the person's dignity, autonomy, and privacy is demonstrated by staff in the use of special procedures. Risk of harm during use or caused by use of special procedures may be low for this person at this time. **3** ☐

- **Poor Use of Special Procedures.** The environment in which the person receives services may be contributing to the emergence of unsafe situations and higher usage of special procedures. Advanced directives and lesser restrictive procedures may not be used due to a poor level of staff training. Special procedures may be over-used or used as a substitute for appropriate treatment. Use of special procedures may be contrary to policies, procedures, and standards of good practice. Respect by staff for the person's dignity, autonomy, and privacy is lacking. Risk of harm during use of special procedures may be moderate. **2** ☐

- **Adverse or Dangerous Use of Special Procedures.** There are serious and dangerous breakdowns in the treatment environment for this person. Respectful relationships and good communications are lacking. Special procedures are being used unnecessarily, inappropriately, unsafely, and without adequate training, authorization, or oversight. Risk of harm during use of special procedures may be high. **1** ☐

- **Not Applicable:** The person has not experienced use of any emergency control measures within the past 90 days. Therefore, this review does not apply. **NA** ☐

PRACTICE REVIEW 11: SUPPORTS FOR COMMUNITY INTEGRATION

SUPPORTS FOR INTEGRATION: • Is the array of in-home and community-based supports provided to this person sufficient [in design, intensity, and dependability] to meet the person's preferences and assist him/her to achieve recovery goals? • Are supports effective during life change adjustments and in maintaining the person within the home, job, and community? • Where applicable, is individually assigned staff (job coach, respite/crisis worker, skills trainer) receiving the education and supports necessary to maintain an appropriate relationship and support arrangement for the person?

Practical supports for community integration consist of agents and/or environmental arrangements that help mediate a gap between a person's capacities and the performance requirements of an environment so that the person can operate successfully in that environment (home, job, or other social setting) under a range of typical conditions. Persons may require such supports to function successfully in daily settings. An array of supports may be required for a person with a serious mental illness to function within the community. To be effective, arrangements for supports have to be designed specifically for the person and setting and then must operate at a level of consistency, intensity, and dependability. Special supports should be thought of as transitional and as having to be acceptable to the person.

In-home supports for adults with serious mental illness/substance use are usually focused on: (1) crisis situations, i.e., the live-in associate or family member feels overwhelmed by the severity of the symptoms of the illness; (2) respite, i.e., the adults need time away from each other for a variety of reasons; and (3) the person has a skills or social deficit or needs that exceed the capacity of the helper in the home. Live-in associates or family members must receive education and training increases their effectiveness as helpers. Extra supports may be required for other reasons; i.e., a new job, temporary child care support, attempts at sobriety, or starting a class at college. The person should have as many choices as possible in selecting the provider, in deciding the intensity of supports, and in defining the nature of support. In general, use of in-home/extra supports should be addressed in the person's recovery plan.

Determine from Informants, Plans, and Records

1. Is this person receiving practical supports in his/her daily settings? If so, how are these designed? How well do current support arrangements enable the person to function successfully in his/her daily settings?

2. Are current supports consistent with the person's recovery plan? Consistent with the person's preferences/culture? Dependable from day to day and from setting to setting? Adjusted to meet changing circumstances? Sufficient to meet the PRGs?

3. Are in-home support services appropriate for the situation, the person's life stage, and accessible when needed, effective when used, and dependable? Have support services ever been denied? If so, why?

4. Given these supports, is the provider able to meet the needs of the person? Is the provider able to maintain the stability of the home and capacity of the person to function adequately over time? Is the person satisfied with the supports provided? Have hardships and disruptions been minimized?

5. If this person presently is residing in a group home or residential treatment facility, does the direct care staff have the capacity to meet the support needs of this person on a daily basis?

6. Has special training, assistance, or support been provided for direct care staff serving this person in the group home/residential treatment facility?

Facts Used in Rating Performance

Practical supports may include:

- *Personal assistant services*
- *Friend and family assistance*
- *Child care or daycare for the person's dependent children*
- *Peer support*
- *Recreation and leisure supports*
- *Case management*
- *Job coach or life coach services*
- *Homemaker services*
- *Assistive technology*
- *Transportation*
- *Internet access*

Informal supports from partners, friends, peers, and family members [where appropriate and available] should be sought and used before paid supports are arranged. In some instances, informal supports may not be available or appropriate.

PRACTICE REVIEW 11: SUPPORTS FOR COMMUNITY INTEGRATION

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person and Home Provider — Rating Level

- **Optimal Supports.** An excellent array of supports and services is planned with and for the person and covered in the person's recovery plan. These services are immediately and consistently accessible as needed, dependable in use, and truly supportive in nature. The person is benefiting from excellent support arrangements in daily settings, fully consistent with his/her needs and choices. Any home provider is receiving an excellent level of training, assistance, in-home support, and periodic relief necessary for the provider to fully meet the needs of the person and maintain the stability of the home living arrangement. The person and home provider choose all support providers to assure cultural compatibility and quality performance over time. **6** ☐

- **Good Supports.** A good and substantial array of supports and services is planned with and for the person and covered in the person's recovery plan. These services are generally accessible as needed, dependable in use, and supportive in nature. The person is benefiting from good support arrangements in daily settings, fully consistent with his/her needs and choices. Any home provider is receiving a good level of training, assistance, in-home support, and periodic relief necessary for the provider to meet the needs of the person and maintain the stability of the home living arrangement. The person and home provider choose most support providers to assure cultural compatibility and quality performance over time. **5** ☐

- **Fair Supports.** A minimally adequate to fair array of supports and services is accessible as needed, adequate in use, and minimally supportive in nature. The person and home provider had minimal involvement in planning supports that are documented in the person's recovery plan. The person is benefiting from fair support arrangements, at least minimally consistent with his/her needs and choices. Any home provider is receiving a minimally adequate to fair level of training, assistance, in-home support, and periodic relief necessary for the provider to meet the needs of the person and maintain the stability of the home living arrangement. The person and home provider choose some support providers to assure cultural compatibility and quality performance over time. **4** ☐

- **Marginal Supports.** There is little evidence that the person or home provider participated in planning of supports. A limited or inconsistent array of supports and services is being provided. The person is receiving marginal support arrangements, somewhat inconsistent with the person's needs and choices. Any home provider is receiving a limited level of training, assistance, in-home support, and periodic relief limiting his/her ability to meet the needs of the person and maintain the stability of the living arrangement. The person and home provider had little, if any, choice in selecting support providers. Cultural compatibility and performance quality of support providers may be somewhat problematic at this time. **3** ☐

- **Poor Supports.** There is little evidence that the person or home provider participated in planning of supports. A poor set of supports and services is being provided. The person is receiving inadequate support arrangements, substantially inconsistent with the person's needs and choices. Any home provider is receiving a poor and inadequate level of training, assistance, in-home support, and periodic relief, thus, undermining his/her ability to meet the needs of the person and maintain the stability of the living arrangement. Neither the person nor home provider had a choice in selecting support providers. Cultural compatibility and performance quality of support providers may be seriously problematic at this time. **2** ☐

- **Absent or Adverse Supports.** There is no evidence that the person or home provider participated in planning of supports. Necessary supports and services are either absent or adverse in effect. The person is receiving either no or harmful support arrangements in daily settings, grossly inconsistent with the person's needs and choices. Any home provider is receiving either no or inappropriate training, assistance, in-home support, and no periodic relief. This situation is seriously reducing the home provider's ability to meet the needs of the person while putting the stability of the home living arrangement at risk. **1** ☐

- **Not Applicable.** Neither the person nor home provider needs or receives supports at this time. **NA** ☐

PRACTICE REVIEW 12: SERVICE COORDINATION & CONTINUITY

SERVICE COORDINATION & CONTINUITY: • Is there a single point of coordination, accountability, and continuity in the organization, delivery, and results of treatment, supports, and services for this person? • Are planned interventions and services well coordinated across providers, funding agencies, and service settings for this person, especially when entering and leaving intensive service settings?

A **single point of coordination, integration, and accountability** is necessary to plan, implement, monitor, modify, and evaluate essential service functions and outcomes for the person, regardless of the number of public funders involved. The single-point person may be referred to as the service coordinator, case manager, or other similar title. Regardless of the title, the person filling this role should have the **competence** necessary to perform essential functions for a person of the complexity of the case being reviewed. This person should have the **authority to convene and communicate with the service team** for purposes of planning, assembling supports and services, monitoring implementation and results, and modifying supports and services. This person should be able to **advocate** on behalf of the person without conflicts of interest that may be associated with a particular funder or provider. The coordinator's caseload size should afford the **opportunity** to adequately coordinate services and provide **continuity of care** for every individual assigned. In a case where several agencies and providers are involved, collaboration is necessary to achieve and sustain a coordinated and effective service process. The primary concern is whether all necessary functions performed by service planners, providers, supporters, and any home provider are organized and integrated to achieve the person's recovery goals.

Determine from Informants, Plans, and Records

1. Does the person require multiple providers to meet his/her needs?
2. Is there a single point of coordination and accountability for implementing plans and for linking the public funders, paid providers, primary care physician, and voluntary resource persons involved?
3. Is there evidence of the integration of services and continuity of effort in the implementation of the person's recovery plans? Is there a mechanism for identifying emerging problems and developing appropriate responses and adjustments in the planning and service process?
4. Is there adequate communication so that all parties know the current status and location of the person?
5. Is the service coordinator sufficiently competent to handle the complexities of this person? Are services well coordinated across settings, providers, levels of care—especially during transitions in/out of intensive services? With the primary care physician and health care providers?
6. Can the service coordinator convene the service team as needed?
7. What is available to assist the coordinator in gaining the cooperation and participation of multiple providers to meet the requirements and commitments of recovery plans, interventions, and services for the person?
8. Can the service coordinator access and use flexible funding if needed?
9. Does the service coordinator and service team collectively share a sense of accountability for helping the person meet recovery goals?

Facts Used in Rating Performance

NOTE:

The accountable agent could be a clinical manager, therapist, case manager, or other designated person.

PRACTICE REVIEW 12: SERVICE COORDINATION & CONTINUITY

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Service Coordination.** There is a highly effective single point of coordination and accountability for the person's services and results. The service coordinator (working in collaboration with the person and service team) fully demonstrates the skills, influence, and opportunity necessary to plan, secure, schedule, coordinate, monitor, and adapt supports and services to achieve desired results for this person. Services are fully integrated across settings and providers and are consistently timely, appropriate, effective, and satisfying to the person. Continuity of care is excellent across providers and settings. **6** ☐

- **Good Service Coordination.** There is a generally effective single point of coordination and accountability for the person's services and results. The service coordinator (working in collaboration with the person and service team) usually demonstrates the skills, influence, and opportunity necessary to plan, secure, schedule, coordinate, monitor, and adapt supports and services to achieve desired results for this person. Services are generally integrated across settings and providers and are usually timely, appropriate, effective, and satisfying to the person/family. Continuity of care is good. **5** ☐

- **Fair Service Coordination.** There is a minimally adequate single point of coordination and accountability for the person's services and results. The service coordinator (working in collaboration with the person and service team) minimally demonstrates the skills and opportunity necessary to plan, secure, schedule, coordinate, monitor, and adapt supports and services. Services are minimally integrated across settings and providers and are at least minimally timely, appropriate, and satisfying. Continuity of care is fair. **4** ☐

- **Marginal Service Coordination.** There is limited coordination of services with little accountability for service delivery and results. The service coordinator (possibly working independently of the person or in the absence of a service team) may lack the skills necessary to plan, secure, schedule, coordinate, monitor, and adapt supports and services. Services are somewhat fragmented across settings and providers. Breakdowns in services may occur occasionally. Providers may have their own agendas that are inconsistent with the IRP. **3** ☐

- **Poor Service Coordination.** There is substantially inadequate coordination of services. The service coordinator (working independently of the person or in the absence of a service team) may lack the skills to plan, secure, schedule, coordinate, monitor, and adapt supports and services. Services are substantially fragmented across settings. Breakdowns may be frequent and risks may not be adequately managed. Inconsistency in approach and service may be obvious among providers. **2** ☐

- **Absent or Adverse Service Coordination.** There is no single point of coordination and accountability for services or results. Providers and funders may operate independently, placing unreasonable or conflicting demands on the person. Needed services may be absent or fragmented. Inappropriate or potentially harmful services may be inadvertently provided. The person may "get lost in the system" for periods of time, leaving him/her at elevated risk of harm or poor outcomes. **1** ☐

PRACTICE REVIEW 13: RECOVERY PLAN ADJUSTMENT

RECOVERY PLAN ADJUSTMENT: • Is the service coordinator using monitoring activities to follow this person's progress, changing conditions, consistency and effectiveness of supports, and results achieved? • Does the service coordinator keep all providers informed and discuss recovery intervention fidelity, barriers encountered, and progress being made? • Are services adjusted in response to problems encountered, progress made, changing needs, and knowledge gained to create a process that supports recovery?

What's working now for this person and, where appropriate, the providers? Are desired treatment results being produced? What things need changing? Continued-stay reviews can serve to monitor service implementation, outcomes, and modify services. These reviews can provide the "learning" and "change" processes that make the treatment process "smart" and, ultimately, effective for the person.

The recovery intervention strategies, services and/or supports should be modified when objectives are met, strategies are determined to be ineffective, new preferences or dissatisfactions with existing strategies or services are expressed, and/or new needs or circumstances arise. The care manager/service coordinator, along with the service team for the person, should play a central role in maintaining onging situational awareness, tracking change strategies and actions supporting recovery, and adjusting planned treatment strategies, services, and supports. Members of the service team (including the person and providers) should apply the knowledge gained through ongoing assessments, monitoring, and periodic evaluations to adapt strategies, supports, and services. The frequency and intensity of the tracking and review process should reflect the pace, urgency, and complexity of the person's needs and unfolding life events.

This learning and change process is necessary in finding what works for the person. Learning what works is a continuing process. Getting successful results depends on a "smart" and adaptive change process.

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
1. How often is the status of the person monitored/reviewed? How does this person participate in the review? How is treatment progress and the person's well-being monitored by the service coordinator and team (e.g., face-to-face contacts, telephone contacts, and meetings with the person and service providers; reviewing reports from providers)?	
2. How is implementation of treatment and service processes being tracked? Is progress or lack of progress being identified and noted?	
3. Are newly identified needs and problems being acted on?	
4. Is there a clear and consistent pattern of successful adaptive service changes that have been made in response to use of short-term results?	
5. Are the PRGs and intervention process modified as goals are met? Is the service process modified if no progress is observed? If not, why not?	
6. How well does the service coordinator and service team update and modify the person' PRGs, intervention strategies, services, and support to keep them relevant to the person's situation and effective in supporting recovery?	

PRACTICE REVIEW 13: RECOVERY PLAN ADJUSTMENT

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Adjustment Process.** Treatment strategies, supports, and services being provided to the person are highly responsive and appropriate to changing conditions and recovery needs. Continuous or frequent monitoring, tracking, and communication of the person's status and service results to the service team [person and other involved providers] are occurring. Timely and smart adjustments are being made. Highly successful modifications are based on a rich knowledge of what things are working and not working for the person. **6** ☐

- **Good Adjustment Process.** Treatment strategies, supports, and services being provided to the person are generally responsive to changing conditions and recovery needs. Frequent monitoring, tracking, and communication of the person's status and service results are occurring. Generally successful adaptations are based on a basic knowledge of what things are working and not working. **5** ☐

- **Fair Adjustment Process.** Treatment strategies, supports, and services being provided to the person are minimally responsive to changing conditions and recovery needs. Periodic monitoring, tracking, and communication of the person's status and service results are occurring. Usually successful adaptations to supports and services are being made. **4** ☐

- **Marginal Adjustment Process.** Treatment strategies, supports, and services being provided to the person are partially responsive to changing conditions and recovery needs. Occasional monitoring and communication of the person's status and service results are occurring. Limited or inconsistent adaptations are based on isolated facts of what is happening. Their status may be adequate in some areas but unacceptable in others. The person and/or caregiver could be at low risk of harm or poor outcomes. **3** ☐

- **Poor Adjustment Process.** Poor treatment strategies, supports, and services may be provided to the person and may not be responsive to changing conditions and recovery needs. Perfunctory monitoring, poor communications, and/or an inadequate service team may be unable to function effectively in planning, providing, monitoring, or adapting services. Few modifications may be planned or implemented. The person's status may be poor in several areas. The person could be at moderate-to-high risk of harm or poor outcomes. **2** ☐

- **Absent, Nonoperative, or Misdirected Adjustment Process.** Treatment strategies, supports, and services may be limited, undependable, or conflicting for the person. No monitoring or communications may occur and/or an inadequate service team may be unable to function effectively in planning, providing, monitoring, or adapting services. Current supports and services may have become nonresponsive to the current needs of the person. The service process may be "out of control" or so limited as to be non-existent. The person's status may be generally poor. The person could be at high risk of harm or poor outcomes. **1** ☐

PRACTICE REVIEW 14: CULTURALLY APPROPRIATE PRACTICE

CULTURALLY APPROPRIATE PRACTICE: • Are any significant cultural issues for the person being identified and addressed in practice? • Are the behavioral health services provided being made culturally appropriate via special accommodations in the person's engagement, assessment, planning, and service delivery processes?

Behavioral health service systems serve an increasing proportion of consumers from under-served minority populations. If such systems are to effectively serve these persons, the impact of culture and diversity must be recognized and accommodated. Cultural accommodations enable practitioners to serve individuals of diverse cultural backgrounds effectively. Such accommodations include valuing cultural diversity, understanding how it impacts on functioning and problems during the course of disease/disorder, and adapting service processes to meet the needs of culturally diverse consumers and their informal supporters. Properly applied in practice, cultural accommodations reduce the likelihood that matters of language, culture, custom, or belief will prevent or reduce the effectiveness of treatment/rehabilitation efforts. The focus of this examination is placed on the person in which significant cultural issues are present in the case that must be understood and accommodated in order for desired treatment results to be achieved. This review does not apply in a case in which matters of native language, culture, custom, or belief are not potential barriers or present impediments in the attainment of desired treatment results. Careful judgment of the reviewer is required in distinguishing the case in which this review applies. The reviewer does not have to be of the same culture as the person but does have to have necessary language skills or interpreter assistance when communicating with the person and his/her family and significant others in making a determination.

Determine from Informants, Plans, and Records

1. Are the person's cultural identity and related needs identified?
2. Are assessments performed appropriate for the person's background?
3. Do the service providers know and respect the person's beliefs and customs?
4. Is the service provider of the same cultural background as this person or does the service provider have adequate knowledge of cultural issues relevant to service delivery for this person and his/her informal supporters?
5. If the person has a primary language that is other than English, are interpreter services provided?
6. Has the service team explored natural, cultural, or community supports appropriate for this person?
7. Has the person expressed any cultural preferences and desires for accommodations? Specific cultural issues identified and addressed are:

   ☐ None
   ☐ Racial:_____
   ☐ Ethnic:_____
   ☐ Religious:_____
   ☐ Other:_____

8. Are cultural differences impeding working relationships or service results with this person and his/her informal supporters? What do they say?
9. If necessary, is the facility able to decide when the rights and preferences of an individual will be limited by the rights and preferences of other individuals in the setting?

Facts Used in Rating Performance

NOTE:

A person's group identity may shape his/her world view and life goals in ways that have to be understood and accommodated in practice. Pentecostals, orthodox Jews, elders, gang members, sexual minorities, deaf, and homeless persons may have their own unique identities, values, beliefs, and world views that shape their ambitions and life choices.

Aspects of Cultural Competence are:

- *Values and attitudes that promote mutual respect.*
- *Communication styles that show sensitivity.*
- *Community/consumer participation in developing policies, practices, and interventions that build on cultural understandings.*
- *Physical environment including settings, materials, and resources that are culturally and linguistically responsive.*
- *Policies and procedures that incorporate cultural/linguistic principles and multi-cultural practices.*
- *Population-based clinical practice that avoids misapplication of scientific knowledge and stereotyping groups.*
- *Training and professional development in culturally competent practice.*

PRACTICE REVIEW 14: CULTURALLY APPROPRIATE PRACTICE

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Person — Rating Level

- **Optimal Practice.** The person's cultural identity is recognized, is well understood, and services are tailored to meet related needs. Cultural beliefs and customs are fully respected and well accommodated in service processes. All assessments are culturally appropriate and limitations or potential cultural biases are recognized. Service providers are fully knowledgeable about issues related to the person's identified culture and shape treatment planning and delivery appropriately. Other individuals important to the person's culture are included in service planning and delivery at the invitation of the person. As needed, interpreter services are provided in a culturally appropriate manner. **6** ☐

- **Good Practice.** The person's cultural identity is recognized and services generally address related needs. Cultural beliefs and customs are generally respected and taken into consideration for planning services. Most assessments are culturally appropriate and limitations or potential cultural bias is recognized. Service providers attempt to gain knowledge about issues related to the person's identified culture and arrange for knowledgeable assistance in treatment planning and service delivery. Other individuals important to the person's culture are acknowledged and information is obtained from them with the agreement of the person. If needed, interpreter services are available. **5** ☐

- **Fair Practice.** The person's cultural identity is recognized and the provider acknowledges this in the assessment, treatment planning, and service delivery process. Cultural beliefs and customs are usually acknowledged and services are planned in an effort to be supportive. For example, the provider might acknowledge other natural community helpers important to the person's culture and works with the person to integrate those supports. If needed, interpreter services are available most of the time. **4** ☐

- **Marginal Practice.** The person's cultural identity is recognized and the provider acknowledges that assessment, treatment planning, or services are <u>not</u> a good fit but is seeking to improve these processes for this person. There may be evidence of cultural accommodations by this behavioral health provider/agency in some cases, although it is limited or inconsistent for this person. Cultural beliefs and customs are not viewed as relevant to the assessment, treatment planning, or service delivery process. If needed, interpreter services are only sporadically available. **3** ☐

- **Poor Practice.** The person's cultural identity is not recognized in the service process. Inappropriate assessment, treatment planning, or service delivery processes ignore the person's cultural beliefs and customs. If needed, interpreter services may be limited or difficult to secure through the behavioral health system. Few, if any, provisions are made for cultural accommodations. **2** ☐

- **Adverse Practice.** There is no evidence of cultural recognition or accommodation by behavioral health service providers in this case. The person's cultural identity may be treated with disrespect and his/her customs and beliefs may be ignored or treated as irrelevant. Inappropriate assessment, treatment planning, or service delivery processes ignore or violate the person's cultural beliefs and customs. If needed, interpreter services are not provided by the behavioral health system. **1** ☐

- **Not Applicable.** The person does not see him/herself of a member of a particular group. **- OR -** The person does not identify any cultural issues or needs relevant for service system performance. **- OR -** The person has not needed or attempted to obtain any behavioral health services in the past six months. **NA** ☐

SECTION 5

OVERALL PATTERNS

OVERALL PERSON DOMAIN

OVERALL PERSON STATUS SCORING PROCEDURE

There are 12 status indicators to be conducted in the area of Person Status. Each review produces a finding reported on a 6-point rating scale. An "overall rating" of Person Status is based on THE REVIEWER'S HOLISTIC IMPRESSION OF THE PERSON'S CURRENT STATUS ON APPLICABLE INDICATORS. The reviewer must consider the unique issues and context for THIS PERSON to arrive at an overall domain rating. (1) Begin by transferring the rating value for each review item from the protocol exam pages to the summation table below. (2) Disregard any indicators deemed not applicable in forming the holistic impression. (3) **Give weight to those items judged to be most important at this time for this individual.** (4) Focusing on those applicable indicators giving them the greatest importance to the person at this time, determine an "overall rating" based on your general impression of the person's status. (5) Mark the box indicating your overall rating below. Report this rating value on the roll-up sheet prepared for this person.

PERSON STATUS INDICATORS

INDICATOR ZONES	IMPROVE	REFINE	MAINTAIN	NA
Community Living	1 2	3 4	5 6	
1a. Safety of the person	☐ ☐	☐ ☐	☐ ☐	
1b. Safety of others	☐ ☐	☐ ☐	☐ ☐	☐
2. Income adequacy & control	☐ ☐	☐ ☐	☐ ☐	
3. Living arrangement	☐ ☐	☐ ☐	☐ ☐	
4a. Social network: composition	☐ ☐	☐ ☐	☐ ☐	
4b. Social network: recovery support	☐ ☐	☐ ☐	☐ ☐	
5a. Satisfaction: person	☐ ☐	☐ ☐	☐ ☐	☐
5b. Satisfaction: caregiver	☐ ☐	☐ ☐	☐ ☐	☐
Physical/Emotional Status				
6. Health/Physical well-being	☐ ☐	☐ ☐	☐ ☐	
7. Substance use	☐ ☐	☐ ☐	☐ ☐	☐
8. Mental health status	☐ ☐	☐ ☐	☐ ☐	
Meaningful Life Activities				
9. Voice & role in decisions	☐ ☐	☐ ☐	☐ ☐	
10. Education/career	☐ ☐	☐ ☐	☐ ☐	☐
11. Work	☐ ☐	☐ ☐	☐ ☐	☐
12. Recovery activities	☐ ☐	☐ ☐	☐ ☐	☐
OVERALL STATUS	☐ ☐	☐ ☐	☐ ☐	

OVERALL PROGRESS PATTERN

OVERALL PROGRESS PATTERN SCORING PROCEDURE

There are 9 possible reviews to be conducted in the area of the Person's Progress. Each review produces a finding reported on a 6-point rating scale. An overall estimate of the Person's Progress is based on THE REVIEWER'S HOLISTIC IMPRESSION OF THE PERSON'S RECENT CHANGES ON APPLICABLE PROGRESS INDICATORS. (1) Begin by transferring the rating value for each progress review item from the protocol page to the summation table below. (2) Disregard any indicators deemed not applicable in forming the holistic impression. (3) Give weight to those items judged to be most important at this time for this person. (4) Focusing on those applicable indicators having the greatest importance to the person at this time, determine an "overall progress pattern" based on your general impression of the person's recent progress. (5) Mark the box indicating your overall rating on item #10 below. Report this rating value on the roll-up sheet prepared for this person.

Person's Progress Pattern

Progress Indicator	Improve		Refine		Maint.		NA
CHANGE OVER TIME	1	2	3	4	5	6	
1. Psychiatric symptoms	☐	☐	☐	☐	☐	☐	☐
2. Substance use impairment	☐	☐	☐	☐	☐	☐	☐
3. Personal responsibilities	☐	☐	☐	☐	☐	☐	☐
4. Education/work	☐	☐	☐	☐	☐	☐	☐
5. Recovery goals	☐	☐	☐	☐	☐	☐	☐
6. Risk reduction	☐	☐	☐	☐	☐	☐	☐
7. Successful life adjustments	☐	☐	☐	☐	☐	☐	☐
8. Improved social integration	☐	☐	☐	☐	☐	☐	☐
9. Meaningful personal relationships	☐	☐	☐	☐	☐	☐	☐
10. OVERALL PROGRESS PATTERN	☐	☐	☐	☐	☐	☐	

OVERALL PRACTICE PERFORMANCE DOMAIN

OVERALL PRACTICE PERFORMANCE SCORING PROCEDURE

There are 14 indicators in the area of Practice Performance. Each review produces a finding reported on a 6-point rating scale. An "overall rating" of practice performance is based on THE REVIEWER'S HOLISTIC IMPRESSION OF THE APPROPRIATE EXECUTION OF PRACTICE FUNCTIONS AND THE DILIGENCE IT SHOWS IN RESPONSE TO THIS PERSON. Consider the fidelity with which each practice function is carried out and whether the intent of the function is being achieved. Overall, is the system taking the necessary actions to appropriately address the individual factors for this person that must be addressed if this person is to make progress toward positive outcomes? (1) Begin by transferring the rating value for each progress review item from the protocol exam pages to the summation table below. (2) Disregard any indicators deemed not applicable in forming the holistic impression. (3) **Give weight to those items judged to be most important at this time for this person**. (4) Focusing on those applicable indicators having the greatest importance at this time, determine an "overall rating" based on your general impression of the practice performance. (5) Mark the box indicating your overall rating below. Report this rating value on the roll-up sheet prepared for this person.

SYSTEM/PRACTICE PERFORMANCE [90-DAY PATTERN]

INDICATOR ZONES	IMPROVE		REFINE		MAINTAIN		NA
Planning Treatment & Support	1	2	3	4	5	6	
1. Engagement of the person	☐	☐	☐	☐	☐	☐	
2a. Teamwork: formation	☐	☐	☐	☐	☐	☐	
2b. Teamwork: functioning	☐	☐	☐	☐	☐	☐	
3. Assessment & understanding	☐	☐	☐	☐	☐	☐	
4. Personal recovery goals	☐	☐	☐	☐	☐	☐	
5. Recovery planning							
a. symptom/SA reduction	☐	☐	☐	☐	☐	☐	☐
b. recovery relapse	☐	☐	☐	☐	☐	☐	☐
c. income/benefits	☐	☐	☐	☐	☐	☐	☐
d. sustainable living supports	☐	☐	☐	☐	☐	☐	☐
e. social integration	☐	☐	☐	☐	☐	☐	☐
f. transitions/adjustments	☐	☐	☐	☐	☐	☐	☐
Providing Treatment & Support							
6. Resources	☐	☐	☐	☐	☐	☐	
7. Intervention adequacy	☐	☐	☐	☐	☐	☐	
8. Urgent response	☐	☐	☐	☐	☐	☐	☐
9. Medication management	☐	☐	☐	☐	☐	☐	☐
10. Seclusion/restraint	☐	☐	☐	☐	☐	☐	☐
Managing Treatment & Support							
11. Support for community integra.	☐	☐	☐	☐	☐	☐	☐
12. Service coordination & continuity	☐	☐	☐	☐	☐	☐	
13. Recovery plan adjustment	☐	☐	☐	☐	☐	☐	
14. Culturally appropriate practice	☐	☐	☐	☐	☐	☐	☐
OVERALL PRACTICE PERFORM.	☐	☐	☐	☐	☐	☐	

SIX-MONTH PROGNOSIS

ESTIMATING THE TRAJECTORY OF THIS PERSON'S EXPECTED COURSE OF CHANGE

Determination of the person's current status and service system performance is based on the observed current patterns as they emerge from the recent past. This method provides a factual basis for determination of current status and service system performance. Forming a six-month prognosis or forecast is based on predicable future events and informed predictions about the expected course of change over the next six months, grounded on known current status and system performance as well as knowledge of tendency patterns found in case history.

If a case were being reviewed in April, then the trajectory point for consideration would be October. Suppose that the person being reviewed has demonstrated a pattern of serious, complex, and recurrent behavior problems that were just being brought under control in April [Overall Status = 4, meaning person's status is minimally and temporarily acceptable; a fact]. Suppose that this person got into trouble with the law last summer [a fact] while homeless [a fact] and lacked adequate support provided via home [a fact]. Suppose this person is to be discharged from the hospital at the end of May [a fact], but has no transition plan for returning to home with supportive services [a fact] following discharge, no planned daytime program or work situation to keep the person engaged [a fact], continuing health problems [a fact], and no current contact or planning with any residential provider expected to admit and serve the person upon discharge [a fact]. Based on what is now known about this person, what is the probability that the person's status in six months (October) will: (1) Improve from a 4 to a higher level? (2) Stay about the same at level 4? or (3) Decline or deteriorate to a level lower than 4? Given this set of case facts plus the person's tendency patterns described in recent history, most reviewers would make an informed prediction that the case trajectory would be downward and that the person's status is likely to decline or deteriorate. One may "hope" for a different trajectory and a more optimistic situation, but "hope " is not a strategy to change the conditions that are likely to cause a decline. Based on the reviewer's six-month prognosis or forecast for this case, the reviewer offers practical "next step" recommendations to alter an expected decline or to maintain a currently favorable situation over the next six months.

Based on what is known about this case and what is likely to occur in the near-term future, the reviewer makes an informed prediction of the prognosis in this case. Mark the appropriate alternative future statement in the space provided below. The facts that lead the reviewer to this view of case trajectory should be reflected in the reviewer's recommendations. Insert your determination in the appropriate space on the roll-up sheet.

Six-Month Prognosis

Based on the person's current status on key indicators, recent progress, the current level of service system performance, and events expected to occur over the next six months, is this person's status expected to improve, remain about the same, or decline or deteriorate in the next six months? (check only one)

☐ **Improve status**

☐ **Continue—status quo**

☐ **Decline/deteriorate**

Explain the rationale for your determination in the oral and written reports presented for this case. Offer practical "next step" suggestions for maintaining positive status or preventing avoidable decline or deterioration.

SECTION 6

REPORTING OUTLINES

WRITTEN CASE REVIEW SUMMARY

Person's Status Summary

Facts about the Person Reviewed

- Agency or Office
- Person's Initials
- Reviewer's Name
- Review Date
- Date of Report
- Person's Placement

People Interviewed during this Review

Indicate the number and role (person, home provider, live-in associated, service coordinator, therapist, job coach, etc.) of the persons interviewed.

Facts About the Person and Living Arrangement
[About 100 words]

- Person's situation and living arrangement
- Reasons for mental health services
- Mental health services received
- Services provided by other agencies

Person's Current Status [About 250 words]
Describe the current status of the person and living arrangement based on status review findings. If any unfavorable status result puts the person at risk of harm, explain the situation. Mention relevant historical facts that are necessary for an understanding of the person's current status. Use a flowing narrative to tell the "case story" and make sure that it supports and adequately illuminates the Overall Status rating.

Home Provider's Status [About 100 words]
Because the status of the person often is linked to the status of any home provider, indicate whether the provider is receiving the supports necessary to adequately meet the needs of the person and maintain the stability of the living arrangement.

Factors Contributing to Favorable Status
[About 100 words]
Where status is positive, indicate the contributions that the person's resiliency, provider capacities, and uses of natural supports and generic community services made to the results.

Factors Contributing to Unfavorable Status
[About 100 words]
Describe what local conditions seem to be contributing to the current status and how the person may be adversely affected now or in the near-term future, if status is not improved.

System Performance Appraisal Summary

Describe the current performance of the service system for this person using a concise narrative form. Mention any historical facts or local circumstances that are necessary for understanding the situation.

What's Working Now
[About 250 words]

Identify and describe which service system functions are now working adequately for this person. Briefly explain the factors that are contributing to the current success of these system functions.

What's Not Working Now and Why
[About 150 words]

Identify and describe any service system functions that are <u>not</u> working adequately for this person. Briefly explain the problems that appear to be related to the current failure of these functions.

Six-Month Prognosis/Stability of Findings
[About 75 words]

Based on current service system performance found in this case, is the person's overall status likely to improve, stay about the same, or decline over the next six months? Take into account current service quality and important life change adjustments that may occur over this time period. Explain your answer.

Practical Steps to Sustain Success and Overcome Current Problems
[About 75 words]

Suggest several practical "next steps" that could be taken to sustain and improve successful practice activities over the next six months. Suggest practical steps that could be taken to overcome current problems and to improve poor practices and local working conditions for this person in the next 90 days.

Report Length
The summary should not exceed two-to-four typed pages, depending on the complexity of the case and the extent of supports and services being provided by various agencies.

REVIEW PRESENTATION OUTLINE

Oral Presentation Outline

1. Core Story of the Person **3 minutes**

- Reason for mental health and other services
- Primary treatment and rehabilitation goals
- Personal recovery goals expressed by the person
- Strengths and needs of the person and home provider
- Services provided by participating agencies

2. Person's Status and, where appropriate, Caregiver Status **3 minutes**

- Overall status of the person finding/rating
- Progress made
- Problems

Emphasize any accomplishments or concerns related to community living, life skills, health, and well-being.

3. System Practice and Performance **3 minutes**

- Overall system performance finding/rating
- What's working now for this person
- What's not working and why
- Six-month prognosis

Emphasize any accomplishments or concerns related to engagement of the person, assessment, planning, treatment, functional support, emergent/urgent response, coordination of services, or results.

4. Next Three Steps **1 minutes**

- Recommended important and doable "next steps"
- Any special concerns or follow-up indicated

Total Presentation Time **10 minutes**

Group Questioning of Presenter **3-5 minutes**

SECTION 7

APPENDICES

GENERAL CASE INFORMATION

Person's Name, Last Name First	Date of Birth	Age	Gender	Race/Ethnicity
	___/ ___/ ___		☐ Male ☐ Female	

Person's Home and, If Appropriate, Caregiver

Person's Present Home Address and Phone Number	Usual Home Address, if different from Present
Address: Phone:	Address: Phone:

Person's Significant Other or Caregiver	Usual Partner/Caregiver, if different from Present
Relationship:	Relationship:

Person's Major Daytime Activity and Contact Person

Person's Current Daytime Activity/Job Location	Usual Daytime Activity Location, if different from Present
Name: Address: Phone:	Name: Address: Phone:

Person's Primary Caseworker/Counselor	Person's Primary Therapist
Person's Title:	Person's Title:

Person's Current Placement Situations

Type of Present Home Placement: check only one

- ☐ Own/personal home
- ☐ Kinship/relative home
- ☐ Friend's home
- ☐ Adult boarding home
- ☐ Supported living
- ☐ Independent living program
- ☐ Group home
- ☐ Detention/jail
- ☐ Hospital/MHI
- ☐ Resid. treatment center
- ☐ Sub. abuse treatment fac.
- ☐ Adult correction facility
- ☐ Homeless/shelter
- ☐ Other: _____

Type of Present Day Activity: check only one

- ☐ Adult education/GED
- ☐ Vocational training/VR
- ☐ Community college
- ☐ Vista/Job Corps
- ☐ Club house
- ☐ Volunteer job
- ☐ Sheltered job
- ☐ Supported employment
- ☐ Competitive employment
- ☐ Street life
- ☐ Partial hospital program
- ☐ Psycho-social rehab.
- ☐ Day treat./activity program
- ☐ Jail activity
- ☐ Other: _____

RESIDENTIAL BEHAVIORAL HEALTH SERVICES RECEIVED

Key Service Activities	Noteworthy Details
Admission Why and by whom was this person referred? Was participation court ordered? How many prior admissions has this person had for acute or residential treatment services?	
Service Planning Explain how present supports and services were planned in terms of what information was relied upon, who participated, how supports and services were determined to be necessary, and how conditions for discharge and transitions were planned.	
Service Implementation Explain how behavioral health services are provided, where and by whom, and with what frequency and intensity. If other related services are provided, indicate how those services are coordinated.	
Service Results/Progress Made Indicate how and by whom results of services are determined. Describe present results related to the reasons for which the person was admitted for services. Indicate progress made toward the reduction of symptoms and functional progress made in managing daily life independently or with little assistance, literacy, GED, employment, housing, and self-management.	
Tracking and Adaptation Explain how and when the tracking of the person's status, implementation of services, review of results, and modification of strategies and services based on results are performed for this person. How are significant others selected by the person involved in these processes? Are services provided timely and effective?	
Care Coordination/Transition Explain plans for transition to community settings, home and work, and community living supports following discharge.	

ISSUES FOR PERSONS IN RESIDENTIAL SETTINGS

Status and Behavioral Health Service Situation	Flag and Note Relevant Findings
Matters for Review and Consideration	√
1. Person has been at this facility for more than 90 days.	☐
2. Person previously has been in a hospital or residential treatment facility.	☐
3. Person qualifies for services under Section 504, IDEA, or Olmstead.	☐
4. Person has an updated individualized recovery plan (IRP) at the facility that is not being implemented on a timely, competent, and consistent basis.	☐
5. Person is "stuck" at the facility due to a court order or administrative problem.	☐
6. Person often breaks "house rules" used at the facility.	☐
7. Person has experienced abuse, neglect, or domestic violence at home.	☐
8. Person has no permanent living arrangement to go/return to after discharge.	☐
9. Person has a co-occurring condition (e.g., addiction) or illness (e.g., diabetes).	☐
10. Person needs vocational training, work experience, independent living services.	☐
11. Person abuses alcohol or substances and needs substance abuse treatment.	☐
12. Person has friends engaged in criminal activities.	☐
13. Person does not speak English or is deaf (cannot communicate with staff/others).	☐

Emergency Procedures Applied to This Person

Type of Emergency Procedure	Occurrences since Admission	Occurrences in Past 30 Days
1. Exclusionary time-outs	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
2. Seclusion/locked room uses	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
3. Take-down/hold procedure	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
4. Physical restraint	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
5. Mobile crisis team intervention	☐ Total count, all occurences: # _____	☐ Total occurrences, past 30 days: #_____
6. ECT	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
7. Experimental protocol	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
8. 911 emergency call for EMS	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
9. 911 emergency call for police	☐ Total count, all occurrences: #_____	☐ Total occurrences, past 30 days: #_____
10.Other: _____	☐ Total count, all occurences: # _____	☐ Total occurrences, past 30 days: #_____

CIRCUMSTANCES THAT MAY REQUIRE MONITORING, SUPPORTS, OR SERVICES

Possible Circumstances of Concern	Note Circumstances as reported by Informants or Records
Person's Life Situation	√
1. Abuse victim with post-traumatic stress.	☐
2. Experiences domestic violence in home.	☐
3. Has no permanent home.	☐
4. Has a chronic illness requiring care.	☐
5. Has a developmental delay/disability.	☐
6. Lives on the streets/homeless.	☐
7. Lacks adequate daily living support.	☐
8. Lacks adequate nutrition.	☐
9. Lacks access to health or dental care.	☐
10. Is HIV positive.	☐
11. Is pregnant or a parent of dependents.	☐
12. Abuses alcohol or drugs.	☐
Behavioral Concerns	
1. Is hurtful to self.	☐
2. Has encounters with law enforcement.	☐
3. Destroys property.	☐
4. Disruptive behaviors.	☐
5. Has unusual or repetitive habits.	☐
6. Presents socially offensive behaviors.	☐
7. Withdrawal or inattentive behaviors.	☐
8. Uncooperative behaviors.	☐

PERSON'S STRENGTHS, CAPACITIES, AND ASSETS TO BUILD UPON

Areas of Interest	Check and Note Circumstances as reported by Informants or Found in Records
The Person and His/Her Friends	√
1. Person has at least one positive long-term adult friend (not family or staff).	☐
2. Friend gives the person feedback that helps redirect energy and behavior.	☐
3. Friend has positive, nurturing interactions with person at least weekly.	☐
4. Friend is willing to be contacted at various times for various reasons.	☐
5. Friend serves as an advocate, providing unconditional support for recovery.	☐
6. Person identifies at least one friend, one professional, and one source of spiritual guidance as significant in his/her life.	☐
7. Person has frequent positive contact with natural family/significant others even when they don't share residence.	☐
8. Extended family and close friends are near and supportive to the person.	☐
9. Family and significant others are willing to learn more about the person's illness.	☐
Person's Life Situation	
10. Person has a stable, appropriate living arrangement/home in good repair.	☐
11. Person has a private room or adequate space for private conversations.	☐
12. Adults sharing or managing the home setting are supportive and helpful.	☐
13. Person has adequate income for basic needs and a stable living arrangement.	☐
14. Person has adequate child care and support for any minor children.	☐
15. Person has adequate transportation.	☐
16. Person completed high school/GED.	☐
17. Person is employed.	☐
18. Person has adequate health care.	☐
19. Person has an advanced directive.	☐
20. Person has a guardian.	☐

COMMUNITY SERVICE PLANNING AND DELIVERY PROCESSES

Key Service Activities	Noteworthy Details	
Identification of Special Needs Explain how this person was identified for services. • Who recognized the need and requested assistance? • How much time passed from the request to the receipt of services? • What systems are involved?		**Time lapsed from referral to services received.** ☐ 1-10 days ☐ 11-20 days ☐ 21-40 days ☐ 41-60 days ☐ 61 + days ☐ UNK/UTD If time lapsed is UNK/UTD how long has the person been receiving services? _____
Support/Service Planning Explain how present supports and services were planned in terms of what information was relied upon, who participated, how supports and services were determined to be necessary, and how resources were identified for implementing the plans.		
Service Implementation Explain how implementation of supports and services is going in terms of what services are provided, where and by whom, and with what frequency and intensity. If other related services are provided, indicate how those services are coordinated.		
Service Results/Progress Made Indicate how and by whom results of services are determined. Describe present results related to the reasons for which the person is provided services. Indicate progress made toward the reduction of risks and progress made toward literacy, recovery, and readiness and opportunity to work, as appropriate to age and situation.		
Tracking and Adaptation Explain how and when the tracking of present status, implementation of services, review of results, and modification of strategies and services based on results are performed for this person. How are significant others selected by the person involved in these processes? Are services provided timely and effective?		

FORMAL SERVICES FOR THE PERSON AND HIS/HER MINOR CHILDREN

	Type of Service	For the Person		For Any Minor Children	
		Needed/Received	Needed/Not Received	Needed/Received	Needed/Not Received
1.	Forensic Residential Services	☐	☐	☐	☐
2.	24-Hour Intensive Staff/Supervision	☐	☐	☐	☐
3.	8-16 Hour Residential Rehabilitation Program	☐	☐	☐	☐
4.	Supported Housing	☐	☐	☐	☐
5.	Specialized Residential (sub. abuse/severe beh.)	☐	☐	☐	☐
6.	Crisis Emergency Telephone/Walk-in/Urgent Care	☐	☐	☐	☐
7.	Crisis Mobile Outreach	☐	☐	☐	☐
8.	Crisis Residential	☐	☐	☐	☐
9.	Respite/In-home Support	☐	☐	☐	☐
10.	Evaluations/Assessment	☐	☐	☐	☐
11.	Court-Ordered Evaluation	☐	☐	☐	☐
12.	Somatic Treatment	☐	☐	☐	☐
13.	Individual Therapy	☐	☐	☐	☐
14.	Group Therapy	☐	☐	☐	☐
15.	Family Therapy	☐	☐	☐	☐
16.	Partial Hospitalization	☐	☐	☐	☐
17.	Outpatient Detoxification	☐	☐	☐	☐
18.	Dual Diagnosis/Day Treatment	☐	☐	☐	☐
19.	Intensive Outpatient Substance Abuse Treatment	☐	☐	☐	☐
20.	Consumer Operated/Community Support Clubhouse/Transitional Employment	☐	☐	☐	☐
21.	Psychosocial Rehabilitation	☐	☐	☐	☐
22.	Supported Employment	☐	☐	☐	☐
23.	Supported and Other Education	☐	☐	☐	☐
24.	Vocational Assessment/Counseling	☐	☐	☐	☐
25.	Consumer Advocacy	☐	☐	☐	☐
26.	Homeless Outreach	☐	☐	☐	☐
27.	Jail Diversion Services	☐	☐	☐	☐
28.	Representative Payee Services	☐	☐	☐	☐
29.	Assertive Community Treatment (ACT)	☐	☐	☐	☐
30.	Active Case Management Services (ICM)	☐	☐	☐	☐
31.	Supportive Case Mgt./Case Coordination	☐	☐	☐	☐
32.	Therapeutic Support & Supervision (Flexible)	☐	☐	☐	☐
33.	Client Transportation	☐	☐	☐	☐
34.	Family Psychoeducation	☐	☐	☐	☐
35.	Legal Advocacy	☐	☐	☐	☐
36.	Family Preservation Services	☐	☐	☐	☐
37.	Parent training and support	☐	☐	☐	☐
38.	Day care/child care	☐	☐	☐	☐
39.	Other _____	☐	☐	☐	☐

ASSESSMENT AND LEVEL OF CARE PLANNING CONSIDERATIONS

Matters of Concern	Notes
1. Risk of harm: • Indication of suicidal or homicidal thoughts or impulses • Indication of physically or sexually aggressive impulses or actions • Developmentally appropriate ability to maintain physical safety • Level of risk for victimization, abuse, or neglect • Binge or excessive use of alcohol or drugs • Engagement in other high risk behaviors, including self-injury • Bingeing/purging, bulimia/anorexia	
2. Functional status/level of impairment: • Consistency of age-appropriate developmental daily living activities • Consistency of age-appropriate academic performance • Consistency of age-appropriate social and interpersonal functioning • Consistency of recent gains in functioning	
3. Co-occurring conditions (comorbidity): • Indications of physical illness or disability • Indications of developmental disability • Indications of substance use or abuse • Indications of psychiatric conditions or forensic involvements • Indications of recent transient, stress-related psychiatric symptoms	
4. Environmental stressors: • Traumatic or enduring disturbing circumstances (e.g., violence, sex abuse) • Recent life transitions or losses of consequence • Transient but significant illness or injury • Expectations of performance at home or work that create discomfort • Disruption of social milieu • Danger or threat in home or neighborhood, including domestic violence • Incarceration, homelessness, or extreme poverty • Racial persecution, immigration, social isolation, language barrier	
5. Environmental support factors for return to home: • Housing/independent living arrangement adequate for person's needs • Family/caregiver's willingness and capacity to support the adult in the home • Special needs met through involvement in various systems of care • Community resources sufficient to meet person's rehabilitation needs	
6. Resiliency and responsiveness to treatment and rehab.: • Ability to deal with stressors and use helpful resources • Motivation to participate in and seek benefit from treatment • Previous treatment history and responsiveness to particular interventions • Persistence of symptoms • Speed of functional improvements • Ability to maintain treatment progress • Ability to manage recovery • Developmental pressures and life changes creating sustained turmoil • Pattern of regression	
7. Acceptance and engagement in the treatment process: • Ability to form a trusting and respectful relationship with service providers • Person's awareness and understanding of goals and treatment plan • Acceptance of responsibility for actions and consequences • Cooperates in treatment planning and treatment activities • Family/caregiver support and participation in treatment activities	

Co-Occurring Conditions

(check all that apply):

- ☐ Mood Disorder
- ☐ Anxiety Disorder
- ☐ PTSD
- ☐ Thought Disorder/Psychosis
- ☐ ADD
- ☐ Substance Abuse/Dependence
- ☐ Personality Disorder
- ☐ Learning Disorder
- ☐ Autism
- ☐ Mental Retardation:
  - ☐ mild
  - ☐ moderate
  - ☐ severe
  - ☐ profound
- ☐ Other Developmental Disability: _____
- ☐ Medical Problem: _____
- ☐ Other: _____

Legal Status/Considerations

(circle all that apply)

- ☐ Probation
- ☐ Parole
- ☐ Charges pending
- ☐ Existing warrants
- ☐ Referral to diversion program
- ☐ Enrolled in diversion program
- ☐ Currently incarcerated
- ☐ Existing restraining order
- ☐ History of restraining orders
- ☐ Civil suits
- ☐ History of incarceration
- ☐ Current participation in re-entry program
- ☐ Guardianship
- ☐ Current house arrest
- ☐ Community Corrections
- ☐ Outpatient Commitment

Recommended Level of Care:

Level	Recommendation
☐ 0	Basic services (prevention)
☐ 1	Recovery maintenance and health management
☐ 2	Low intensity community-based
☐ 3	High intensity community-based
☐ 4	IL, SILP
☐ 5	Medically monitored residential services
☐ 6	SOF

REVIEWER'S ASSESSMENT OF THE PERSON'S GENERAL LEVEL OF FUNCTIONING

*Rate the person's general level of functioning over the **LAST 30 DAYS** using the DSM-IV-R Axis V, Global Assessment of Functioning scale. Rate actual current functioning, regardless of treatment or prognosis. Rely on interview results obtained from the person, caregiver, job coach, service coordinator, therapist, and/or service providers and on recent assessments presented in the case record. The levels reported below represent the **REVIEWER'S ASSESSMENT**, based on interviews, records, and direct observation, when possible.*

Level	Levels of Functioning to be Used by the Reviewer in Determining the Person's General Level of Functioning
91-100	Superior functioning in all areas (at home, at school/work, with peers, in the community); involved in a wide range of activities and has many interests (e.g., has hobbies, participates in extracurricular activities, belongs to an organized group); likable, confident; "everyday" worries never get out of hand; doing well in daily activities; getting along with others; behaving appropriately; no symptoms.
81-90	Good functioning in all areas: secure in family, in school/work, and with peers; there may be transient difficulties but "everyday" worries never get out of hand (e.g., mild anxiety about an important life event; occasional "blow-ups" with friends, family, or peers).
71-80	No more than slight impairment in functioning at home, at school/work, with peers, and in the community; some disturbance of behavior or emotional distress may be present in response to life stresses (e.g., parental separation, death, birth of a child, loss of job), but these are brief and interference with functioning is transient; such persons are only minimally disturbing to others and are not considered deviant by those who know them.
61-70	Some difficulty in a single area, but generally functioning pretty well (e.g., sporadic or isolated antisocial acts, such as occasionally smoking pot or minor difficulties with rule/law breaking; mood changes of brief duration; fears and anxieties that do not lead to gross avoidance behavior; self-doubts); has some meaningful interpersonal relationships; most people who do not know the person well would not consider him/her deviant but those who know him/her well might express concern.
51-60	Variable functioning with sporadic difficulties or symptoms in several but not all social areas; disturbance would be apparent to those who encounter the person in a dysfunctional setting or time but not to those who see the person in other settings.
41-50	Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school/work refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor or inappropriate social skills, isolation, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.
31-40	Major impairment in functioning in several areas and unable to function in one of these areas; i.e., disturbed at home, at school/work, with peers, or in society at large; e.g., persistent aggression without clear instigation, markedly withdrawn and isolated behavior due to either thought or mood disturbance, suicidal attempts with clear lethal intent; such persons are likely to require intensive supports and/or hospitalization (but this alone is not a sufficient criterion for inclusion in this category).
21-30	Unable to function in almost all areas, e.g., stays at home, in a ward, or in a bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (e.g., sometimes incoherent or inappropriate).
11-20	Needs considerable supervision to prevent hurting self or others (e.g., frequently violent, repeated suicide attempts, self-injurious behavior), failure to maintain self-care routines, refusal to eat or maintain one's health, or gross impairment in all forms of communication (e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, isolation).
1-10	Needs constant supervision (24-hour care) due to severely aggressive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect, or self-care.
0	Inadequate information.

Notes	Present Level - Today
	Overall Level: _____

CASE MANAGER/CARE COORDINATOR INFORMATION

- How long have you been employed with this mental health agency? _____
- What is you current position/job title? _____
- How long have you been in your current position? _____
- How long have you been assigned to this case? _____
- Do you serve this person only as his/her care coordinator? Or, do you serve as this person's therapist or life coach also?_____

  _____
- How many care coordinators have been assigned to this case before you (if any)? _____
- How many open cases do you currently have? _____
- In your perspective, are there any barriers or limitations that prevent you from providing good service coordination in this case? Please explain your answer in the space provided below.

  _____

  _____

  _____
- Describe clinical supervision you receive for this particular case: _____

  _____

  _____

  _____
- Other membes of the CMHC treatment team: _____

  _____

  _____

CONSUMER SERVICES REVIEW PROFILE - ADULT

1. GENERAL REVIEW INFORMATION

0. **Record Number:** _____

1. **Person's Name:** _____

2. **County:** _____

Provider: _____

3. **Counselor/Caseworker:** _____

Agency: _____

4. **Review Date:** _____/ _____/ _____

5. **Reviewer:** _____ **Shadow**: _____

6. **Number of persons interviewed:** ☐

2. LIVING ARRANGEMENT

7. Living arrangement *(check only one)*

☐ Own/personal home
☐ Kinship/relative home
☐ Friend's home
☐ Adult boarding home
☐ Supported living
☐ Independent living program
☐ Group home
☐ Detention/Jail
☐ Hospital/MHI
☐ Residential treatment center
☐ Substance abuse treatment facility
☐ Adult correction facility
☐ Homeless/shelter
☐ Other: _____

3. CO-OCCURRING CONDITIONS

Identify the co-occurring conditions *(check all that apply)*:

☐ 8. Mood Disorder
☐ 9. Anxiety Disorder
☐ 10. PTSD
☐ 11. Thought Disorder/Psychosis
☐ 12. ADD
☐ 13. Substance Abuse/Dependence
☐ 14. Personality Disorder
☐ 15. Learning Disorder
☐ 16. Autism
☐ 17. Mental Retardation:
  ☐ mild ☐ moderate
  ☐ severe ☐ profound
☐ 18. Other Develop. Disability: _____
_____
☐ 19. Medical Problem: _____
☐ 20. Other: _____
☐ 21. None

4. DEMOGRAPHIC AND SERVICE INFORMATION

22. Person's Age

☐ 18-29 yrs
☐ 30-49 yrs
☐ 50-69 yrs
☐ 70 + yrs

23. Gender

☐ Male
☐ Female

24. Ethnicity

☐ Euro-American
☐ African-American
☐ Latino-American
☐ American Indian
☐ Asian-American
☐ Pacific Is. American
☐ Other: _____

25. Case Open

☐ 0 - 3 mos.
☐ 4 - 6 mos.
☐ 7 - 12 mos.
☐ 13-24 mos.
☐ 25-36 mos.
☐ 37-60 mos.
☐ 61+ mos.

26. Placement Changes

☐ None
☐ 1-2 placements
☐ 3-5 placements
☐ 6-9 placements
☐ 10+ placements

27a. Time Lapsed from Referral to Services Rec.

☐ 0-10 days
☐ 11-20 days
☐ 21-40 days
☐ 41-60 days
☐ 61 + days
☐ UNK/UTD

28. Level of Care:

☐ 0. Basic services (prevention)
☐ 1. Recovery maintenance & health mgt.
☐ 2. Low intensity community-based services
☐ 3. High intensity community-based services
☐ 4. IL, SILP
☐ 5. Medically monitored residential services
☐ 6. SOF

27b. Length of Time Receiving Services _____

5. DEMOGRAPHIC AND SERVICE INFORMATION

29. Primary Daytime Activities: *(check all that apply)*

☐ Adult Ed./GED
☐ Voc. training/VR
☐ Comm. college
☐ Vista/Job Corps
☐ Club house
☐ Volunteer job
☐ Sheltered job
☐ Support. employ.
☐ Compet. employ.
☐ Street life
☐ Partial hosp. program
☐ Psycho-social rehab.
☐ Day treatment/activity prog.
☐ Jail activity
☐ Other: _____

30. Months with Current Provider: *(check only one item)*

☐ 0 - 3 mos.
☐ 4 - 6 mos.
☐ 7 - 9 mos.
☐ 10 - 12 mos.
☐ 13 - 18 mos.
☐ 19 - 36 mos.
☐ 37+ mos.

31. Number of Psychotropic Medications Prescribed: *(check only one item)*

☐ No psych meds
☐ 1 psych med
☐ 2 psych meds
☐ 3 psych meds
☐ 4 psych meds
☐ 5+ psych meds

32. Person's Global Assessment of Functioning Level: *(check only one item)*

[See CSR Adult Protocol, page 96 for Global Assessment of Functioning]

☐ GAF ≤ 40 ☐ GAF 41-60 ☐ GAF ≥ 61 ☐ Not available

Emergency (1-hour) & Urgent (24 hour) Responses in Past 30 Days:

33. No. Emergency Responses

☐ None ☐ 6-9
☐ 1-2 ☐ 10-19
☐ 3-5 ☐ 20+

34. No. Urgent Responses

☐ None ☐ 6-9
☐ 1-2 ☐ 10-19
☐ 3-5 ☐ 20+

6. DEMOGRAPHIC AND SERVICE INFORMATION

Special Procedures Used in Past 30 Days: *(check all that apply)*

☐ 35. Voluntary Time Out
☐ 36. Loss of Priviledges via a Point & Level System
☐ 37. Disciplinary Consequences for Rule Violation
☐ 38. Room Restriction
☐ 39. Exclusionary Time Out
☐ 40. Seclusion/Locked Room
☐ 41. Take-Down Procedure
☐ 42. Physical Restraint (hold, 4-point, cuffs)
☐ 43. Emergency Medications
☐ 44. Medical Restraints
☐ 45. 911 Emergency Call: EMS
☐ 46. 911 Emergency Call: Police
☐ 47. Other: _____
☐ 48. NONE

49. Residential Placement in past 30 days, if different from current placement: *(check only one)*

☐ Family/Adoptive Home
☐ Kinship/Relative Home
☐ Foster Home (regular or therapeutic)
☐ Private Residential Facility
☐ Group Home
☐ Residential Treatment Center
☐ Youth Services Facility
☐ Hospital/Institution
☐ Other: _____
☐ Not Applicable

7. LENGTH OF TIME IN CURRENT LIVING ARRANGEMENT

50. Months in Current Living Arrangement: *(check only one item)*

☐ 0 - 3 mos.
☐ 4 - 6 mos.
☐ 7 - 9 mos.
☐ 10 - 12 mos.
☐ 13 - 18 mos.
☐ 19 - 36 mos.
☐ 37+ mos.

FAX TO 850/422-8487

CONSUMER SERVICES REVIEW PROFILE - ADULT

Page 2: Person's Name: _____ Reviewer: _____ Date: ___/___/___

8. PERSON STATUS INDICATORS

INDICATOR ZONES	IMPROVE		REFINE		MAINTAIN		NA
Community Living	1	2	3	4	5	6	
1a. Safety of the person	☐	☐	☐	☐	☐	☐	
1b. Safety of others	☐	☐	☐	☐	☐	☐	☐
2. Income adequacy & control	☐	☐	☐	☐	☐	☐	
3. Living arrangement	☐	☐	☐	☐	☐	☐	
4a. Social network: composition	☐	☐	☐	☐	☐	☐	
4b. Social network: recovery support	☐	☐	☐	☐	☐	☐	
5a. Satisfaction: person	☐	☐	☐	☐	☐	☐	☐
5b. Satisfaction: caregiver	☐	☐	☐	☐	☐	☐	☐
Physical/emotional Status							
6. Health/Physical well-being	☐	☐	☐	☐	☐	☐	
7. Substance use	☐	☐	☐	☐	☐	☐	☐
8. Mental health status	☐	☐	☐	☐	☐	☐	
Meaningful Life Activities							
9. Voice & role in decisions	☐	☐	☐	☐	☐	☐	
10. Education/career	☐	☐	☐	☐	☐	☐	☐
11. Work	☐	☐	☐	☐	☐	☐	☐
12. Recovery activities	☐	☐	☐	☐	☐	☐	☐
OVERALL STATUS	☐	☐	☐	☐	☐	☐	

9. PERSON'S PROGRESS PATTERN

Progress Indicator	Improve		Refine		Maint.		NA
CHANGE OVER TIME	1	2	3	4	5	6	
1. Psychiatric symptoms	☐	☐	☐	☐	☐	☐	☐
2. Substance use impairment	☐	☐	☐	☐	☐	☐	☐
3. Personal responsibilities	☐	☐	☐	☐	☐	☐	☐
4. Education/work	☐	☐	☐	☐	☐	☐	☐
5. Recovery goals	☐	☐	☐	☐	☐	☐	☐
6. Risk reduction	☐	☐	☐	☐	☐	☐	☐
7. Successful life adjustments	☐	☐	☐	☐	☐	☐	☐
8. Improved social integration	☐	☐	☐	☐	☐	☐	☐
9. Meaningful personal relationships	☐	☐	☐	☐	☐	☐	☐
10. OVERALL PROGRESS PATTERN	☐	☐	☐	☐	☐	☐	

10. SYSTEM/PRACTICE PERFORMANCE [90-DAY PATTERN]

INDICATOR ZONES	IMPROVE		REFINE		MAINTAIN		NA
Planning Treatment & Support	1	2	3	4	5	6	
1. Engagement of the person	☐	☐	☐	☐	☐	☐	
2a. Teamwork: formation	☐	☐	☐	☐	☐	☐	
2b. Teamwork: functioning	☐	☐	☐	☐	☐	☐	
3. Assessment & understanding	☐	☐	☐	☐	☐	☐	
4. Personal recovery goals	☐	☐	☐	☐	☐	☐	
5. Recovery planning							
a. symptom/SA reduction	☐	☐	☐	☐	☐	☐	☐
b. recovery relapse	☐	☐	☐	☐	☐	☐	☐
c. income/benefits	☐	☐	☐	☐	☐	☐	☐
d. sustainable living supports	☐	☐	☐	☐	☐	☐	☐
e. social integration	☐	☐	☐	☐	☐	☐	☐
f. transitions/adjustments	☐	☐	☐	☐	☐	☐	☐
Providing Treatment & Support							
6. Resources	☐	☐	☐	☐	☐	☐	
7. Intervention adequacy	☐	☐	☐	☐	☐	☐	
8. Urgent response	☐	☐	☐	☐	☐	☐	☐
9. Medication management	☐	☐	☐	☐	☐	☐	☐
10. Seclusion/restraint	☐	☐	☐	☐	☐	☐	☐
Managing Treatment & Support							
11. Support for community integra.	☐	☐	☐	☐	☐	☐	☐
12. Service coordination & continuity	☐	☐	☐	☐	☐	☐	
13. Recovery plan adjustment	☐	☐	☐	☐	☐	☐	
14. Culturally appropriate practice	☐	☐	☐	☐	☐	☐	☐
OVERALL PRACTICE PERFORM.	☐	☐	☐	☐	☐	☐	

11. SIX-MONTH PROGNOSIS

Based on review findings, over the next six months the person's situation is likely to:

☐ **Improve** ☐ **Continue—status quo** ☐ **Decline/deteriorate**

12. REVIEW OUTCOME CATEGORY

(See Person's Overall Status and Overall Practice Performance):

☐ **Outcome 1** (+ status, + perf) ☐ **Outcome 2** (– status, + perf) ☐ **Outcome 3** (+ status, – perf) ☐ **Outcome 4** (– status, – perf)

APPOINTMENTS

APPOINTMENT 1

Date: ____/ ____/ _____ Time: ____ : _____

Person: _____

Title: _____

Agency: _____

Address: _____

Phone: _____

Directions to Appointment 1

APPOINTMENT 2

Date: ____/ ____/ _____ Time: ____ : _____

Person: _____

Title: _____

Agency: _____

Address: _____

Phone: _____

Directions to Appointment 2

APPOINTMENT 3

Date: ____/ ____/ _____ Time: ____ : _____

Person: _____

Title: _____

Agency: _____

Address: _____

Phone: _____

Directions to Appointment 3

APPOINTMENT 4

Date: ____/ ____/ _____ Time: ____ : _____

Person: _____

Title: _____

Agency: _____

Address: _____

Phone: _____

Directions to Appointment 4

APPOINTMENT 5

Date: ____/ ____/ _____ Time: ____ : _____

Person: _____

Title: _____

Agency: _____

Address: _____

Phone: _____

Directions to Appointment 5

Help Resources

Review Team Leader: _____ Phone: _____

Local Contact Person: _____ Phone: _____